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Health Services

2002/03
Annual Service Plan Report

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Ministry of Health Services
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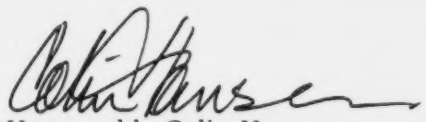
Accountability Statements

Minister of Health Services

The 2002/03 Ministry of Health Services Annual Service Plan Report was prepared under my direction and in accordance with the *Budget Transparency and Accountability Act*. This report compares the actual results to the expected results identified in the ministry's 2002/03 Service Plan. I am accountable for the ministry's results and the basis on which they have been reported.



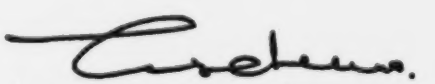
Honourable Colin Hansen
Minister of Health Services

June 23, 2003

Minister of State for Mental Health

I am the Minister of State for Mental Health. Under the *Balanced Budget and Ministerial Accountability Act*, I am accountable for the achievement of the following results and the basis on which the related portion of the 2002/03 Ministry Annual Service Plan Report was prepared. Information on actual results will not be available until December 2003. At that time, I will release an updated accountability statement.

- Increasing the percentage of mental health clients receiving services in their own region.
- Increasing the proportion of mental health clients accessing community services.
- Ensuring no increase in the number of days spent by mental health patients in hospitals, after the need for hospital care has ended.
- Achieving a three per cent increase in the number of persons hospitalized for a mental health diagnosis who received community or physician follow-up within 30 days of discharge.
- Increasing mental health services funding (including capital) per capita by 4.2 per cent.



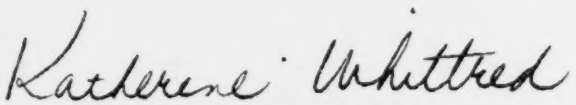
Honourable Gulzar Cheema
Minister of State for Mental Health

June 23, 2003

Minister of State for Intermediate, Long Term and Home Care

I am the Minister of State for Intermediate, Long Term and Home Care. Under the *Balanced Budget and Ministerial Accountability Act*, I am accountable for the achievement of the following results and the basis on which the related portion of the 2002/03 Ministry Annual Service Plan Report was prepared. Information on actual results will not be available until December 2003. At that time, I will release an updated accountability statement.

- Increasing by two per cent the percentage of home and community care clients with high care needs living in their own home rather than in a facility.
- Decreasing by five per cent the percentage of days spent by patients in hospitals, after the need for hospital care has ended.



Honourable Katherine Whittred
Minister of State for Intermediate,
Long Term and Home Care

June 23, 2003

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BRITISH COLUMBIA

Ministry of Health Services

I am pleased to present the 2002/03 Annual Service Plan Report for the Ministry of Health Services. This report highlights the progress this province has made in achieving our vision to create a health system that provides quality health services to meet patients' needs. During the past year, we have continued to work towards our *New Era* commitments to modernize our health care system and focus resources on providing patient-centred care.

British Columbia's health care system faces many challenges. These include shortages in health human resources, upgrading hospital facilities, the need for flexible care options for a changing and aging population, and new, expensive medical equipment and technology. We've taken steps to address these challenges and to improve the delivery of services.

And, because they're key to our health system, we have made BC nurses and doctors among the highest paid in the country. As an example, we have implemented a province-wide strategy that brings together incentive programs for doctors working in rural communities to ensure fair and equitable access to medical services for BC families, regardless of where they live.

To address the needs of people with mental illness, we've committed $263 million to fully implement BC's mental health plan and expand facilities and care options for British Columbians.

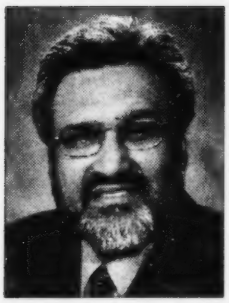
Our government has also launched a Home and Community Care Strategy to modernize and improve care options for seniors and people with disabilities. By 2006, we will provide 5,000 care beds, and as a step toward that goal, we're opening new supportive living units in areas of the province. These options help address the diverse and changing needs of British Columbians, and promote independence, choice and quality of life.

We continue to work with BC's health authorities, care providers and other partners to make improvements to our health system. Our government has significantly increased BC's health spending by $1.1 billion — to a total of $10.4 billion in 2002/03. This means that almost 41 per cent of our total provincial budget is put towards delivering quality patient care.

While additional resources provide part of the solution, more must be done to develop innovative approaches to both meet the challenges and create the opportunities to better serve seniors, families and communities in our province.

Honourable Colin Hansen
Minister of Health Services

Message from the Minister of State for Mental Health



Our government is committed to creating an effective, sustainable health system that meets the health care needs of British Columbians. Premier Gordon Campbell created my position as BC's first Minister of State for Mental Health to ensure a clear understanding of mental health issues — and to be an advocate across government for revitalizing mental health services in our province.

Working with health authorities and other partners, our government has successfully developed and implemented a multi-year $125 million mental health plan. This provincial plan includes strategies to better meet the needs of patients with mental illness, and provides an additional $138 million for new facilities. Through our $263 million investment, we're moving away from institutional treatment, and we're making a shift towards a responsive health system that provides appropriate care to British Columbians, where they live and when they need it.

Some of the key achievements highlighted in this annual service plan report include provincial reports and tools to help health authorities develop strategies for better preventing and treating depression and anxiety disorders. These reports outline innovative ways to enhance public education, deliver and access services, and evaluate the health and wellness of patients.

In our province, we are fully aware and committed to reforming mental health — and making it a priority on the provincial agenda. Clearly, to achieve our vision of modernizing mental health services and our health system, we must continue working with patients, care providers and communities to improve the quality of life of people with mental illness.

The 2002/03 Annual Service Plan Report for the Ministry of Health Services highlights the goals, initiatives and achievements of our province, partners and communities in creating a supportive system for the care and recovery of British Columbians.

Honourable Gulzar Cheema
Minister of State for Mental Health

Message from the Minister of State for Intermediate, Long Term and Home Care

When Premier Gordon Campbell appointed me as BC's first Minister of State for Intermediate, Long Term and Home Care, I was given the mandate to ensure our health system offered the flexible care options that British Columbians want and need.

The 2002/03 Annual Service Plan Report for the Ministry of Health Services outlines key priorities, goals and initiatives for increasing care options to meet the needs of seniors, people with disabilities and others. This work will offer greater independence, choice and quality of life for British Columbians — and help those with high care needs live at home, in their communities. Toward this *New Era* goal, we are improving care and investing more in long-term and home care services.

I am pleased to say that we've moved forward on BC's Home and Community Care Strategy, making a continuum of services available, from institutional care to home care services delivered in local communities.

Under our direction, health authorities are embarking on a major redesign of their home and community care services. This includes 5,000 care beds by 2006, including thousands of assisted living units, of which 3,500 will be built under the Independent Living BC Program with BC Housing. As well, it ensures a more appropriate use of residential care facilities, enhancing home care services, and expanding the palliative care benefits program in BC.

These are just a few of the ways we are meeting our *New Era* commitments. I am proud of the work we have done so far to ensure all people have access to appropriate care for their needs, in appropriate settings — settings that respect people's rights and give them the dignity and support they need.

We've taken important steps in the right direction. And we look forward to another year of working to ensure British Columbians will have access to the support and services they need and value.

Katherine Whittred

Honourable Katherine Whittred
Minister of State for Intermediate, Long Term and Home Care

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Introduction

The 2002/03 fiscal year marks the second year of activity directed to meeting government's goal of creating a patient-centred public health care system that provides accessible, high-quality services, improves health and wellness, and is sustainable over the long term.

Building on the work started in 2001/02 to consolidate health authorities, clarify roles and responsibilities, and establish clear accountability for outcomes, the ministries worked this year to strengthen the current health system, while making it more adaptable to changing needs.

Efforts in the Ministry of Health Services centred on ensuring BC's health care providers received the information, direction and corporate support needed to ensure British Columbians received timely, appropriate and accountable care in their communities and health facilities, within an affordable provincial framework.

At the same time, the Ministry of Health Planning focused on putting in place the building blocks for a responsive, sustainable and well-managed health system by creating the policy, budgetary and legislative frameworks needed to address current and future challenges and enable the health system to move forward on a strong, evidence-based foundation.

The November 2002 release of *The picture of health: How we are modernizing British Columbia's health care system* provided the public and health care community with a detailed description of the direction BC's health care system will be moving over the coming years. In 2002/03, the Ministry of Health Planning concentrated on working with health care providers, plus diverse health experts and academics, patients and interest groups, and decision-makers at all levels, to determine the best paths to follow to achieve that direction.

Year-at-a-Glance Highlights

Providing the right care in the right setting . . .

Service redesign efforts this year focused on shifting the mix of services and care providers to ensure patient care is delivered at the most appropriate level and setting. These efforts will help create an integrated network of services that will allow patients to get the care they need and to move seamlessly between settings and providers. To facilitate this:

- In April 2002, BC's new health authorities release *Health Service Redesign Plans* outlining their strategies to begin creating a seamless high-quality and sustainable network of care for patients in their communities.
- April also sees the introduction of the *Residential Access Policy*, marking a major shift toward providing access to the province's residential care facilities based on need, and ensuring spaces are available to the people who need them most.
- In September 2002, construction begins on *a new mental health facility in Kamloops* and *Seven Oaks Mental Health Facility* opens in Victoria, as part of the province's plan to ensure people with mental illness have increased access to care in their communities. In March, the following year, an expanded psychiatric unit at St. Joseph's Hospital in Comox is opened.
- In November 2002, the *Community Care and Assisted Living Act* passes, modernizing the regulation of community care facilities and supporting the development of assisted living units. The recently opened 59-unit Nikkei Home in Burnaby provides a tangible example of how these care arrangements will respond to seniors' demands for a wider variety of flexible options.
- Also in November 2002, BC receives $74 million in a federal funding commitment over four years to develop sustainable improvements to *Primary Health Care* and increase patient access to comprehensive, high-quality services in doctors' offices and community clinics — the usual "first points of contact" with the health care system.
- And in February 2003, *a $58.5 million benefits and incentives package* is rolled out to attract doctors to rural communities and improve access for patients living there.

Providing the right care to the right people . . .

Work was also undertaken this year to improve access to specialized care for British Columbians with specific illnesses. For example:

- In April 2002, *a comprehensive Chronic Disease Web site* is launched, designed to help both patients and providers with the prevention and management of common chronic diseases. This year, work is also completed on a patient registry for diabetes, as well as clinical practice guidelines for diabetes and for Hepatitis B and C.

- In November 2002, the *Interior Health Tele-Imaging System* is officially launched in Kamloops, allowing medical images to be transferred digitally and giving patients in the Interior faster access to expertise and information.
- And in March 2003, a *Provincial Strategy for Emergency Room Services* is launched, highlighting work coordinated by the Provincial Health Services Authority to improve the effectiveness and accessibility of emergency department services.

Keeping people as healthy as possible . . .

This year, the ministry also intensified efforts to protect and promote a healthier population — with the goal of improving public health and the sustainability of BC's health system over time. Specific highlights include:

- A comprehensive $16 million action plan to strengthen *drinking water protection* and safeguard public health and safety is announced in June 2002.
- *More than 27,000 BC First Nations Health Handbooks* — designed to address unique health care needs and increase awareness of the BC NurseLine — are distributed to First Nations households, band council offices, and friendship centres in January 2003.
- In February 2003, the province's *immunization program expands* to better protect children at high-risk for bacterial meningitis, ear and throat infections, and pneumonia, through an additional $18 million funding commitment. This program will be fully implemented in 2005/06.
- And in March 2003, when the outbreak of Severe Acute Respiratory Syndrome (SARS) presents an unexpected national challenge, *BC's integrated planning and public health platform* allows it to respond quickly and comprehensively to contain the impact of this public health threat. Shortly after, investments in health research pay off when British Columbia researchers lead the world to map the genetic structure of the SARS virus.

Managing the health system within budget . . .

In keeping with the commitment to make BC's health system sustainable over the long term, the ministries and health authorities explored a wide range of options and alternatives to improve the efficiency and effectiveness of service delivery, while maintaining accountability to British Columbians. This includes determining how to engage private sector innovation and expertise within a publicly funded and administered health care system. Specifically:

- In December 2002, after extensive consultation, government retains therapeutic substitution as an effective measure to *protect public access to important classes of drugs*, while committing to a broad review of PharmaCare and working with industry and health professionals on other cost-containment strategies.
- In January 2003, government moves forward with the *creation of a long-awaited hospital and cancer centre in Abbotsford* through a unique public-private sector partnership. This arrangement allows limited public resources for capital projects to be leveraged

through private sector involvement, while protecting the public health system. The year also sees the creation of the *Patient Service Delivery Policy Framework*, allowing the ministry to partner with the private sector in the provision of certain clinical services within the framework of the *Canada Health Act*.

- And in February 2003, *Fair PharmaCare* is announced, modernizing the provincial drug insurance plan to make it more equitable and ensure financial assistance with prescription drug costs and other medical supplies is available to those families who need it most.

Planning and support to strengthen our health system . . .

2002/03 marked a significant shift in the way the Ministries of Health collect and report information, and how they use that information for health planning decisions. These decisions can range from how to treat depression effectively, to how health services are used in various regions. BC made significant progress this year providing both information and investments in infrastructure to support the health system. For example:

- September 2002 sees the release of *nationally agreed upon health indicators* for the first time ever. BC was able to report on more indicators than any other jurisdiction, with evidence showing British Columbians were generally healthy and had a quality health system on which they could depend. This report, entitled "How Healthy are We?" is available on the Ministry of Health Planning's Web site in both detailed and summary versions.
- In October 2002, the Minister of State for Mental Health releases *the Provincial Depression Strategy Report* and the *Provincial Anxiety Disorders Strategy Report*, outlining innovative and effective ways to increase awareness and deliver services.
- Also, over the last year, government announces *$134 million to expand medical school facilities* at the University of British Columbia and establish satellite medical programs at the University of Northern British Columbia and the University of Victoria.
- In December 2002, *$21.5 million is made available to educate, recruit and retain nurses*, including $10.7 million from the Ministry of Advanced Education. These dollars fund several initiatives, including new nursing education seats, grants for approximately 200 nurses to take upgrading or refresher courses to return to the nursing profession, and specialty or continuing education opportunities for over 1,000 nurses. Also this year, health science education seats are increased for allied health workers such as medical imaging technologists, medical laboratory technologists and respiratory therapists. As well, new education spaces are provided for midwifery and resident care attendants.
- And in February 2003, health experts from around the world meet with the minister, key stakeholders and decision makers in BC to add advice and expertise to the BC health planning process. A comprehensive *Industry Analysis and Summary of Expert Input* is compiled for the ministry's public Web site.
- In February 2003, in further support for evidence-based health care, $8 million was provided to the Michael Smith Foundation for Health Research to conduct research for improving the effectiveness of health care reforms.

Ministry Roles and Services

Introduction

Since June 2001, the government has introduced major reforms to improve patient care and modernize BC's health care system. These include innovations and improvements to achieve the following goals for health care:

- To provide high quality, patient-centred care;
- To improve the health and wellness of British Columbians; and
- To create an affordable, sustainable health services system.

BC's health services system was designed for an earlier era with services and care focused on sudden acute care needs. Over the years, an aging population and increase in chronic diseases have put new demands on our health system. We are now focused on creating a flexible, adaptable health system to meet the diverse and changing needs of British Columbians.

The Ministries of Health Services and Health Planning share a common vision, mission, values, goals and objectives. Although both ministries work towards shared goals and objectives, each has unique roles and responsibilities, as expressed by the different service plan strategies each is following to achieve them.

Ministry Vision, Mission and Values

Vision

A health system that ensures high quality public health care services that meet patients' needs, where they live and when they need them.

Mission

To guide and enhance the province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health.

The top priorities are saving and renewing public health care and providing high quality public health care services that meet patients' most essential needs.

Values

Consistent with the principles of the *Canada Health Act*, our values define our organizational behaviour:

Patient and Consumer Focus *which respects the needs and diversity of all British Columbians.*

Equity *of access and in the quality of services delivered by government.*

Access *for all to required health services.*

Effectiveness *of delivery and treatment leading to appropriate outcomes.*

Efficiency, *providing lowest cost consistent with quality services.*

Appropriateness, *providing the right service at the right time in the right place.*

Safety *in the delivery of health services to minimize the risks to the health and safety of British Columbians.*

Goals

The Ministries of Health Services and Health Planning share the following goals:

1: High Quality Patient-Centred Care

Patients receive appropriate, effective, quality care at the right time in the right setting and health services are planned, managed and delivered around the needs of the patient.

2: Improved Health and Wellness for British Columbians

Support British Columbians in their pursuit of better health through protection, promotion and prevention activities.

3: A Sustainable, Affordable Public Health System

A planned, efficient, affordable and accountable public health system, with governors, providers and patients taking responsibility for the provision and use of these services.

Ministry Overview

The Ministry of Health Services provides funding, direction and leadership to regional health authorities to support the delivery of quality health services throughout the province. In turn, the health authorities run the health system's day-to-day operations. The ministry also provides operational support to the Ministry of Health Planning. In addition, the ministry oversees and operates PharmaCare, the province's drug insurance program, and the Medical Services Plan to ensure British Columbians get the physician services and pharmaceuticals they need.

In 2002/03, the BC government increased funding for health care to a total of $10.4 billion. This represents 40.6 per cent of total government spending, the highest health budget ever in BC.

Ministry Operating Context

Environmental Scan

BC faces a number of challenges in creating a health system that provides quality, appropriate care that meets the changing and diverse health care needs of British Columbians.

Demographic Trends

- BC's population will increase by 39,000 persons in 2003 and 49,000 in 2005.
- BC residents' median age continues to increase from 35.5 years in 1995 to 39.7 years in 2005.
- The number of BC residents over 65 increases yearly and will comprise 13.8 per cent of the population in 2005.
- There will be a decrease in the number of residents under 19 as part of BC's total population.
- The health sector's workforce is aging.

Fiscal Challenges

- Annual growth in BC's health care costs puts pressure on health budgets — even with new federal multi-year funding.
- Increasing demand for health care and resources, fuelled by a growing and aging population, higher service expectations and inflation.
- Uncertainty with performance of the provincial economy, public demand and provider supply add to challenges of effective planning.

Key Cost Drivers

- Wage and benefit pressures across the health sector.
- Rapidly rising pharmaceutical costs.
- Emerging illnesses and new treatments increase health care costs.
- Pressure from the public and providers for government to fund new technologies, prescription drugs and clinical interventions.
- Necessary investments in updating and purchasing new facilities or equipment.
- Changing demographics in BC — a growing and aging population.

Challenges and Risks

- Health care planning is impacted by emerging diseases, population growth, changes in demographics, health human resources, clinical practices and new technologies. For example, a flu epidemic or new cases of Severe Acute Respiratory Syndrome (SARS) would change patients' immediate health care needs.
- Attracting and retaining highly qualified health professionals at a time of global shortages of care providers.
- The focus on "patients first" requires a shift in management and provider culture.
- Managing the health care system and the restructuring of the Ministries of Health during a period of fixed health system budgets.

Implications for the Ministries of Health

The goal of health care renewal in BC is to address these very challenges while providing a responsive and well-managed health care system. This renewal process is also designed to ensure sustainability of BC's system in the face of looming cost drivers and increasing demands for services by a growing and aging population.

The restructuring of the health ministries and the health authorities in 2001/02 has been an important first step. It helped to clarify roles and responsibilities of all the health system partners. The Ministries of Health have expertise in health care planning and management and are building stronger relationships with health system partners, who deliver health services. Capitalizing on these two strengths will be critical to delivering quality care and modernizing the health system for the 21st century. In particular, the ministry is:

- Using planning and projection tools to forecast services required to meet the health care needs of all British Columbians, in the short and long-term;
- Involving experienced staff and external experts with extensive knowledge of the issues facing BC's health system;
- Introducing innovative planning and management practices;
- Developing and implementing standards of care and accountability to improve the delivery of health services and patient outcomes;
- Leading, monitoring and reporting on system performance and accountability;

- Fostering cooperative working relations with health system partners and among various ministry areas;
- Building relationships with other provincial ministries in BC and ministries in other provinces and territories to coordinate services; and
- Streamlining the Ministries of Health to focus on core businesses and priority issues.

The 2003/04 – 2005/06 service plans for both ministries present the three-year plan for meeting the province's health care goals and objectives. These reports are available at www.gov.bc.ca/healthservices or www.gov.bc.ca/healthplanning.

Update on *New Era* Commitments

In June 2001, the Premier of British Columbia gave the Minister of Health Services the responsibility of implementing 23 of government's *New Era* commitments. Please refer to Appendix 3 for a status on each of these *New Era* commitments.

Core Business Areas

At the beginning of 2002/03, the Ministry of Health Services had four core business areas: Performance Management and Improvement Division; Emergency Health Services; Medical and Pharmaceutical Services; and Corporate Services and Financial Accountability.

These represented the four divisions of the ministry. During the year, these functions were integrated into three new core business areas:

- Services Delivered by Partners
- Services Delivered by the Ministry
- Stewardship and Corporate Management

These core businesses better reflect the functions of BC's health care system as a whole, as well as the different roles of the ministries and their health care partners.

Services Delivered by Partners

BC's regional health authorities, agencies, doctors and other care providers are our key partners who deliver the majority of health services to the public. They are responsible for identifying patients' needs, planning and allocating health resources, and managing the delivery of health services throughout the province. Health services managed and delivered by our health system partners include the following:

- Prevention, protection and promotion including public health programs, health information campaigns, inspections and licenses; and
- Primary or episodic care — often the first point of contact — such as doctors' visits, acute care, specialist care, rehabilitation services, and ongoing chronic or palliative care.

Health authorities are responsible for the delivery of the majority of these services, including running public health programs and providing acute care services at hospitals. They also manage the delivery of home and community care and mental health services to address patients' needs. Doctors and pharmacists are other key system partners in delivering these services.

Services Delivered by Ministry

Health Benefit Operations

As part of the Ministry of Health Services, Health Benefit Operations administers BC's PharmaCare and Medical Services Plan. PharmaCare is the province's drug insurance program, which assists British Columbians with paying for eligible prescription drugs and medical supplies. The Medical Services Plan (MSP) insures medically required services provided by physicians and supplementary health care practitioners, as well as laboratory and diagnostic services.

Emergency Health Services

The ministry also funds Emergency Health Services delivered by the British Columbia Ambulance Service.

Stewardship and Corporate Management

In their stewardship role, both ministries provide leadership and support to health authorities and other partners in delivering quality health services to the public. The Ministries of Health establish funding, performance agreements for health authorities, and performance measures for BC's health system. Their role includes monitoring and evaluating health system performance and service delivery in order to facilitate improvements. In addition, the ministries support the health system and their partners through negotiations with care providers, as well as decision support systems.

Corporate management includes managing ministry budgets, human resources and information needs. The Ministry of Health Services provides support and funding for these shared management functions across both ministries. Both Ministries of Health also provide support to the Ministers' Offices.

Strategic Initiatives and Corporate Services

Strategic Initiatives and Corporate Services oversees priority initiatives of the ministry, such as the implementation of Fair PharmaCare. The division also provides corporate support services for both health ministries, including information management, human resources and finance. Working with the Performance Management and Improvement Division, it also establishes financial performance standards and monitoring systems for BC's health authorities. Finally, the division provides financing for capital health projects.

Performance Management and Improvement Division

The Performance Management and Improvement Division is the main link between the province and the regional health authorities, which are responsible for the direct delivery of many health services in BC. These services include acute care, residential and community care, mental health and public health services. The division works with health authorities, service providers and other partners to implement performance agreements, accountability standards and monitoring systems. The ministry provides three-year funding allocations to health authorities for health service delivery in their local communities.

Medical and Pharmaceutical Services

The Medical and Pharmaceutical Services Division is responsible for the management of medical services through policy development, systems improvements and effective issues resolution. The division also manages physician relations through strategic planning, policy development, negotiated agreements, and the development of patient strategies and policies. In addition, Medical and Pharmaceutical Services manages BC PharmaCare — the province's public drug insurance program that subsidizes eligible prescription drugs and medical supplies, protecting British Columbians from high drug costs.

Performance Reporting

Overview

In February 2002, the Minister of Health Services tabled the ministry's 2002/03 - 2004/05 service plan in the Legislature, marking the first time a three-year, transparent accountability planning framework had been introduced for the health sector.

Overall, the ministry made considerable progress in implementing its strategies and achieving its performance objectives, meeting most of its 2002/03 targets. Since releasing the 2002/03 service plan the ministry has gained a greater understanding of data collection cycles, the availability of health data and the most appropriate venues for reporting different types of health information. As some of the data required for the ministry to report on particular performance measures are not available for up to 12 months following the end of the fiscal year, the ministry will be publishing a supplement to the annual service plan report each December.

In consultation with a variety of agencies, including BC's health authorities, the Auditor General, Treasury Board and the Caucus Committee on Health, the ministry worked this year to review and refine some of its performance measures in ways that would be more relevant to the public. This means retained measures will also more clearly focus on areas where the ministry or its partners have a significant influence over outcomes, and changes in results can be expected within a three-year reporting time frame. The 2002/03 performance measures that do not meet these criteria will continue to be reported through other more appropriate venues such as the Provincial Health Officer's Annual Report, the Vital Statistics Annual Report, and the health indicators reports of the Performance Indicator Reporting Committee and the Canadian Institute of Health Information.

By continuing to refine the manner in which the ministry collects data, reports information and liaises with key provincial, national and international data sources, BC will ensure the performance targets set in the service plans for the Ministries of Health continue to evolve and have meaning for British Columbians. Where changes occur in these measures from year to year, they will be duly reported in the service plan and the annual service plan report.

Interpreting the Results

The following section details the ministry's progress in implementing its 2002/03 service plan strategies and achieving its performance measure targets. The reader is encouraged to use the following key to interpret the results.

Strategies: Implementation Status	Performance Measures: Assessment Against Target
Completed — strategy was completed in 2002/03.	**Met (or Exceeded) Target** — 2002/03 target was achieved.
Ongoing — the strategy is now part of the ongoing operational activities of the ministry.	**Missed Target** — 2002/03 target was not achieved. This is accompanied by an explanation of the variance.
Underway — strategy was initiated in 2002/03.	**Pending** — assessment against the target is pending as 2002/03 data was not available at report production time.

Ministry Goals, Objectives, Key Strategies, and Performance Measures

Goal 1: High Quality Patient Centred Care	
Objective 1: Health services are delivered according to best practices and standards.	
Strategies:	
• Work with health authorities and providers to implement and audit health service standards.	Underway
• Introduce strategies to improve the care of people with chronic health conditions.	Underway

Achievements:

- Performance agreements were established to outline expectations for health authorities' performance. A framework is being developed for monitoring levels of care, such as acute care and mental health services within each health authority.
- BC established patient registries for diabetes and congestive heart failure so that health professionals can be proactive in scheduling tests and providing information.
- Targets for rates of compliance with diabetes testing standards were established. More protocols and standards are under development for congestive heart failure, asthma and other chronic health conditions.
- Chronic disease management Web site was established, including a secure Web site for practitioners to help assess level of care provided against BC standards.
- Planning for physician collaboratives was completed. These will facilitate the development and distribution of evidence-based practice guidelines.

Performance Measures

Rates of compliance with selected protocols and standards (Goal 1: PM#1)

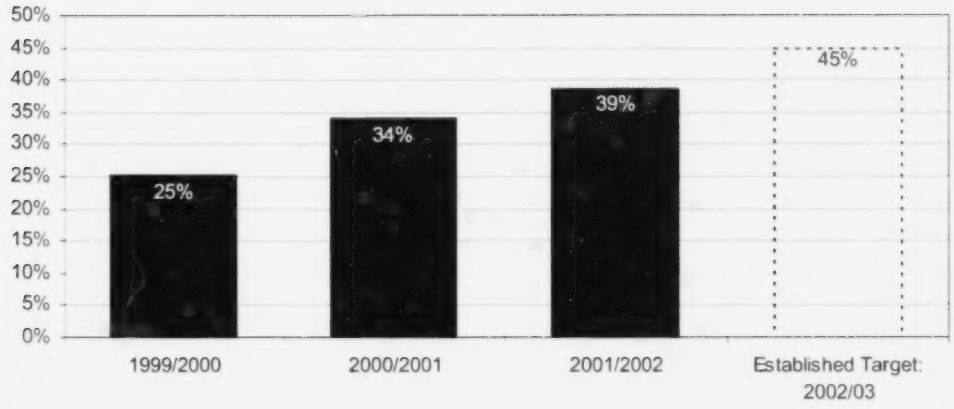
This indicator measures the number of patients with chronic illness who receive services that meet the standards and guidelines set by health professionals.

The 2002/03 measurement is of the percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year, as set in BC's diabetes guidelines. Diabetes is one of the most common chronic diseases, affecting about five per cent of Canadians, and its prevalence is expected to increase significantly due to an aging population and rising rates of obesity. Blood glucose tests help flag potential complications for persons with diabetes.

Results

2002/03 Target	2002/03 Actual	Status
Consider conditions and set targets in collaboration with the British Columbia Medical Association (BCMA)	Targets were established to measure the percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year. Established Target 02/03: 45% Target 03/04: 55% Target 04/05: 60% Target 05/06: 65%	Met target

Percentage of Patients with Diabetes Receiving at least 2 Blood Glucose (HbA1c) Tests During the Year



Notes: The analysis was based on individuals who:

a. received 2 or more physician services (on different dates) paid by MSP within 365 days coded 250 (diabetes mellitus) since 1991; or
b. had 1 or more hospital discharges coded 250 since 1991; or
c. received insulin, oral hypoglycaemics, or testing strips paid for in part by PharmaCare since 1991; and
d. received one or more MSP-paid services in the 2001/02 fiscal year.

Source: BC Diabetes Registry, Population Health Surveillance and Epidemiology Branch, MSP Economic Analysis Branch.

Performance Measures

Rates of compliance with selected protocols and standards (Goal 1: PM#1)

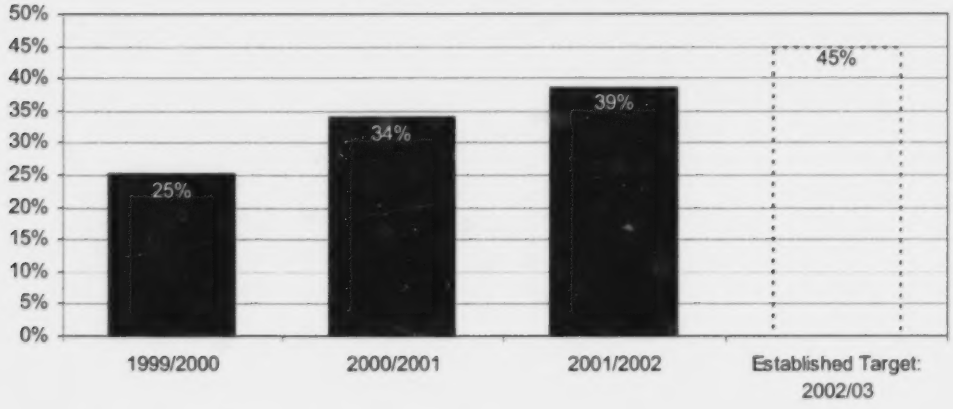
This indicator measures the number of patients with chronic illness who receive services that meet the standards and guidelines set by health professionals.

The 2002/03 measurement is of the percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year, as set in BC's diabetes guidelines. Diabetes is one of the most common chronic diseases, affecting about five per cent of Canadians, and its prevalence is expected to increase significantly due to an aging population and rising rates of obesity. Blood glucose tests help flag potential complications for persons with diabetes.

Results

2002/03 Target	2002/03 Actual	Status
Consider conditions and set targets in collaboration with the British Columbia Medical Association (BCMA)	Targets were established to measure the percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year. Established Target 02/03: 45% Target 03/04: 55% Target 04/05: 60% Target 05/06: 65%	Met target

Percentage of Patients with Diabetes Receiving at least 2 Blood Glucose (HbA1c) Tests During the Year



Notes: The analysis was based on individuals who:

a. received 2 or more physician services (on different dates) paid by MSP within 365 days coded 250 (diabetes mellitus) since 1991; or
b. had 1 or more hospital discharges coded 250 since 1991; or
c. received insulin, oral hypoglycaemics, or testing strips paid for in part by PharmaCare since 1991; and
d. received one or more MSP-paid services in the 2001/02 fiscal year.

Source: BC Diabetes Registry, Population Health Surveillance and Epidemiology Branch, MSP Economic Analysis Branch.

Goal 1: PM#2a, 2b, and 2c

- **PM#2a: 30-day in-patient mortality or death rates for acute myocardial infarction (heart attack) and stroke**
- **PM#2b: 5-year survival rates for lung, prostate, breast and colorectal cancer; relative survival rates for heart attack (365 days after admission to hospital) and stroke (180 days after admission)**
- **PM#2c: Hospital re-admission rates for heart attack, congestive heart failure, pneumonia, and gastro-intestinal hemorrhage**

Results

2002/03 Target	2002/03 Actual	Status
Set targets	Performance measures not carried forward	See explanatory note below

Data for these three performance indicators cannot be provided within the required time frame of the *Budget Transparency and Accountability Act* and the *Balanced Budget and Ministerial Accountability Act*. As these measures are national health indicators, they will continue to be reported publicly in the Performance Indicator Reporting Committee and Canadian Institute of Health Information indictor reports.

Source: AMI and Stroke: BC administrative databases; Discharge Abstract Database / Hospital Morbidity database (CIHI); POI database, Vital Statistics files, and life tables (Statistics Canada); ISQ.

Goal 1: High Quality Patient-Centred Care	
Objective 2: Care is provided at the appropriate level in the appropriate setting.	
Strategies:	
• Rationalize and redesign hospital care.	Underway
• Reallocate resources and develop policy to support innovative community, home care and palliative care services as alternatives to institutional care.	Underway
• Provide 5,000 new home and community care placements (beds).	Underway
• Implement an integrated health information system to facilitate better patient care across programs.	Underway

Achievements:

- Regional health authorities are at various stages of consolidating acute care services and creating inter-linked systems of small community hospitals or treatment centres for basic emergency services, larger community hospitals and regional referral centres.
- A new Residential Access Policy was introduced to ensure that admittance to long-term care facilities is based on need.
- The government passed the *Community Care and Assisted Living Act* to modernize regulation of care facilities, enable more local decision making to ensure appropriate care options, and support development of assisted living units.
- Across the health authorities, 3,500 assisted living units are being provided under the Independent Living BC program, and additional units are being made available through other partnerships.
- Finally, a strategic visionary plan and an annual tactical plan have been completed for developing a provincial information system that will improve patient care. A key goal is to connect health professionals and facilities to allow development of an electronic health record for each patient. This will enable better decisions about the health care provided and ensure appropriate care at all levels.

Performance Measures

Rates of admission for conditions that could be managed outside hospital (classified as *may not require hospitalization*) (Goal 1: PM#2d)

May Not Require Hospitalization (MNRH) shows the rate of hospital admissions for conditions that could be managed outside hospital. This measure can help identify opportunities to reduce some categories of inpatient admissions and redirect care to others requiring hospital services.

2002/03 data from the Canadian Institute of Health Information (CIHI) is not available at this time due to delays in the cross-Canada implementation of a new classification scheme (ICD10-CA).

Results

2002/03 Target	2002/03 Actual	Status
5% decrease Baseline: 2000/01	Data for 2001/02 and 2002/03 not yet available	Pending*

* Data for this measure will be available, pending the review and redevelopment of case mix groups by CIHI.

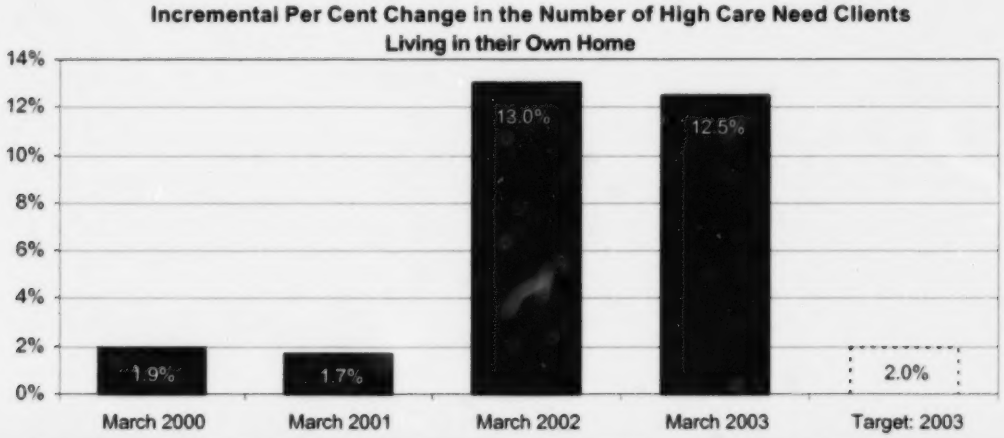
Source: Discharge Abstract Database, Information Support, Regional Programs, BC Ministry of Health; Population tables from PEOPLE26, BC Stats.

Percentage of home and community care clients with high care needs living in their own home (intermediate care level 3 or above) (Goal 1: PM#3a)

This indicator tracks the number of seniors and people with disabilities who have high care needs and receive home support or adult day care, allowing them to remain more independent and autonomous in their own home. Clients with high care needs are those who require intermediate or extended care — intermediate care level 3 or higher.

Results

2002/03 Target	2002/03 Actual	Status
2% increase in the number of high care needs clients Baseline: 2001/02	12.5% increase	Exceeded target



	March 1999	March 2000	March 2001	March 2002	March 2003
Number of High Care Need Clients Living in their Own Home	6,292	6,414	6,523	7,370	8,292

Notes:

1. Home and community care clients living in their own home refer to those receiving home support and adult day care.
2. Those in residential care facilities refer to those in residential facilities, group homes and family care, and excludes mental health clients.
3. High care needs clients are those clients at intermediate care level 3 or above.
4. Counts of clients are made at a point in time. Data shown in the table are for March of each year.

Source: Continuing Care Information Management Systems, Continuing Care Data Warehouse.

Alternate Level of Care (ALC) days as a percentage of total inpatient days
(Goal 1: PM#3b)

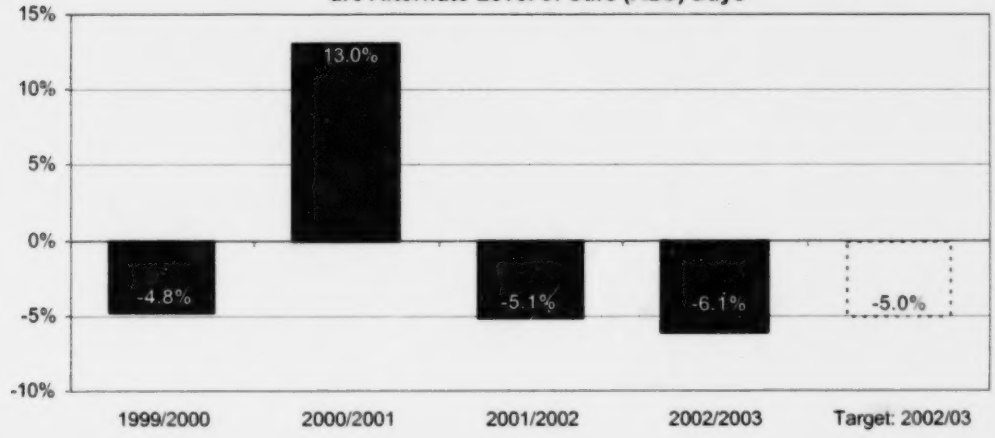
This measure indicates if patients have timely access to appropriate care in the most appropriate setting. The days that patients spend in hospital after their need for acute care has ended are called Alternate Level of Care (ALC) days. Patients remain in hospital longer than necessary for various reasons, including no available room in residential facilities or a delay in discharge arrangements. A reduction in ALC days results in more acute care beds being available for those who need acute care.

Results

2002/03 Target	2002/03 Preliminary*	Status*
5% decrease Baseline: 2001/02	6.1% decrease	Exceeded target

* Data are based on preliminary results to September 2002. Final results will be released in December in a supplement to this annual report.

Incremental Per Cent Change in the Proportion of Hospital In-patient Days that are Alternate Level of Care (ALC) Days



	1999/2000	2000/2001	2001/2002	2002/2003*	Target: 2002/2003
ALC Days	379,930	424,922	387,511	362,117	
Inpatient Days	2,750,961	2,730,992	2,613,268	2,608,313	
Per Cent	13.8%	15.6%	14.8%	13.9%	13.2%

Notes:
1. 2002/03 data are based on preliminary data to September 2002.
2. Total inpatient days include acute care, rehabilitation and alternate level of care/discharge planning (no newborns).
3. ALC days include all days coded alternate level of care or discharge planning.
4. The data includes primary diagnosis and primary procedure only.

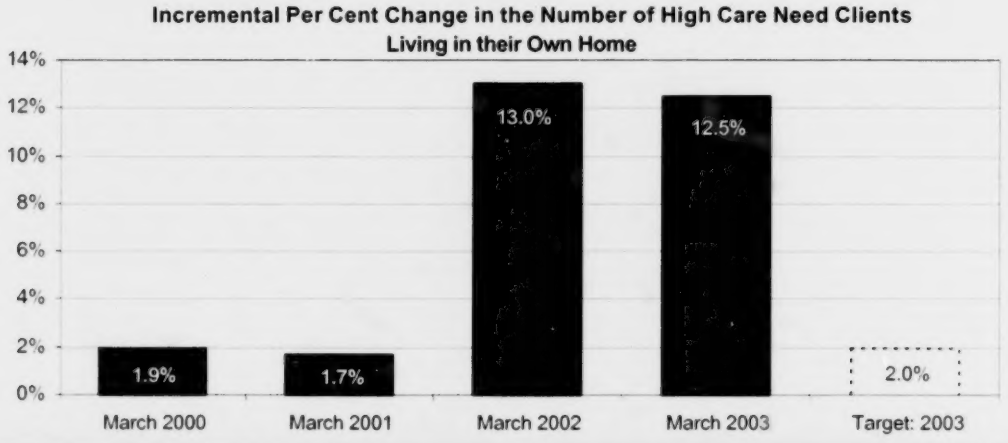
Source: Discharge Abstract Database, Information Support, Ministry of Health Services.

Percentage of home and community care clients with high care needs living in their own home (intermediate care level 3 or above) (Goal 1: PM#3a)

This indicator tracks the number of seniors and people with disabilities who have high care needs and receive home support or adult day care, allowing them to remain more independent and autonomous in their own home. Clients with high care needs are those who require intermediate or extended care — intermediate care level 3 or higher.

Results

2002/03 Target	2002/03 Actual	Status
2% increase in the number of high care needs clients Baseline: 2001/02	12.5% increase	Exceeded target



	March 1999	March 2000	March 2001	March 2002	March 2003
Number of High Care Need Clients Living in their Own Home	6,292	6,414	6,523	7,370	8,292

Notes:

1. Home and community care clients living in their own home refer to those receiving home support and adult day care.
2. Those in residential care facilities refer to those in residential facilities, group homes and family care, and excludes mental health clients.
3. High care needs clients are those clients at intermediate care level 3 or above.
4. Counts of clients are made at a point in time. Data shown in the table are for March of each year.

Source: Continuing Care Information Management Systems, Continuing Care Data Warehouse.

Alternate Level of Care (ALC) days as a percentage of total inpatient days
(Goal 1: PM#3b)

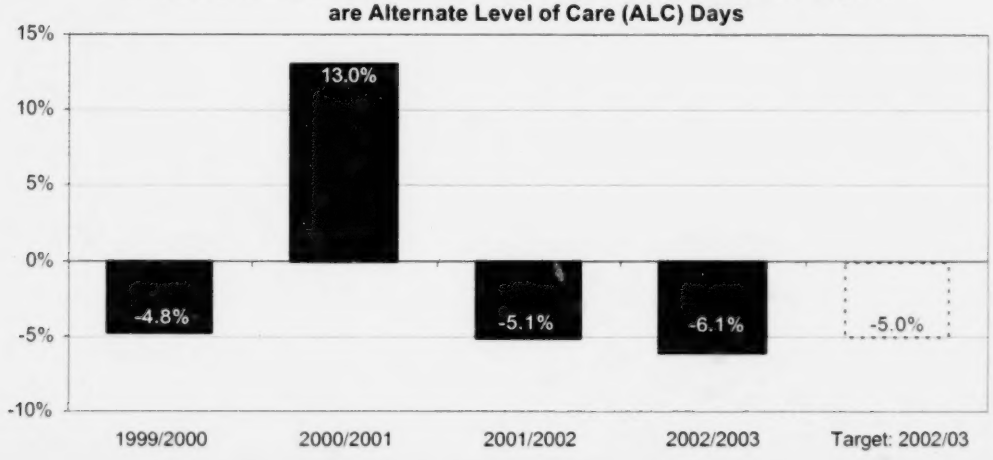
This measure indicates if patients have timely access to appropriate care in the most appropriate setting. The days that patients spend in hospital after their need for acute care has ended are called Alternate Level of Care (ALC) days. Patients remain in hospital longer than necessary for various reasons, including no available room in residential facilities or a delay in discharge arrangements. A reduction in ALC days results in more acute care beds being available for those who need acute care.

Results

2002/03 Target	2002/03 Preliminary*	Status*
5% decrease Baseline: 2001/02	6.1% decrease	Exceeded target

* Data are based on preliminary results to September 2002. Final results will be released in December in a supplement to this annual report.

Incremental Per Cent Change in the Proportion of Hospital In-patient Days that are Alternate Level of Care (ALC) Days



	1999/2000	2000/2001	2001/2002	2002/2003*	Target: 2002/2003
ALC Days	379,930	424,922	387,511	362,117	
Inpatient Days	2,750,961	2,730,992	2,613,268	2,608,313	
Per Cent	13.8%	15.6%	14.8%	13.9%	13.2%

Notes:
1. 2002/03 data are based on preliminary data to September 2002.
2. Total inpatient days include acute care, rehabilitation and alternate level of care/discharge planning (no newborns).
3. ALC days include all days coded alternate level of care or discharge planning.
4. The data includes primary diagnosis and primary procedure only.

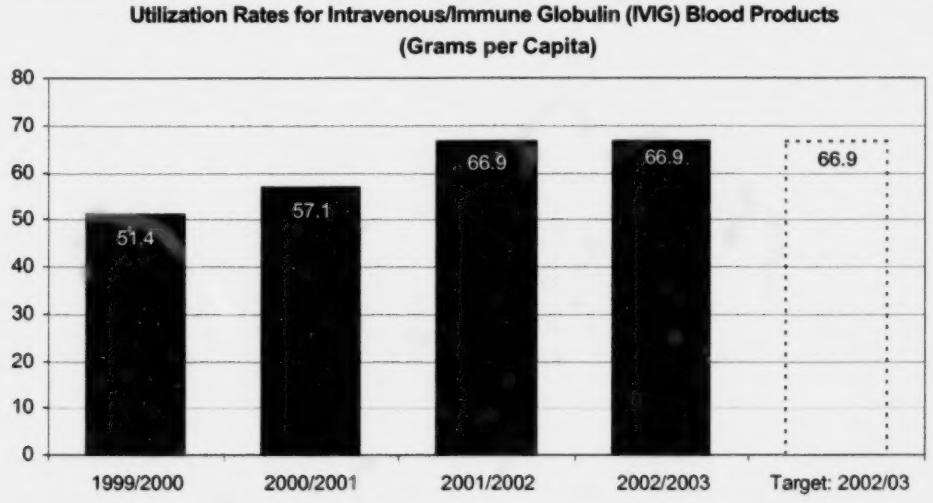
Source: Discharge Abstract Database, Information Support, Ministry of Health Services.

Appropriate use of blood products for clinical purposes measured by utilization of Intravenous/Immune Globulin (IVIG) Blood Products (Goal 1: PM#5)

This indicator measures the use of intravenous immune globulin (IVIG), a blood product made from human plasma. This blood product is licensed for treating some clinical conditions. However, it is also being used for treating conditions not supported by medical research. The average cost of IVIG therapy is approximately $70 per gram and the cost per course of treatment regularly exceeds $10,000. Through the Provincial Blood Coordinating Office, the ministry has implemented an IVIG Utilization Management Project to monitor the use of IVIG with the goal of stabilizing and reducing use of this treatment option.

Results

2002/03 Target	2002/03 Actual	Status
Stable (at 66.9 grams per capita) Baseline: 2001/02	Stable	Met target



Source: Canadian Blood Services

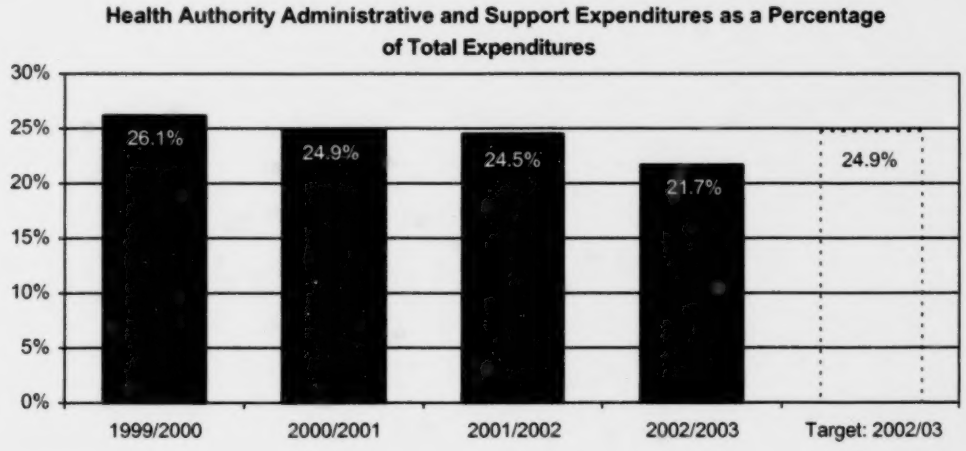
Administrative and support services expenditures as a percentage of total expenditures, by health authority (Goal 1: PM#8)

This indicator measures the amount that health authorities spend on administrative and support services, compared to their total expenditures. Administrative services include finance services, human resources and communications. Support services include maintenance, housekeeping, food services and security. This indicator helps health authorities plan their spending and ensure every available dollar is directed towards delivering patient care.

Results

2002/03 Target	2002/03 Preliminary*	Status*
Maintain 2000/01 percentage (24.9%) Baseline: 2000/01	Percentage decreased to 21.7%	Exceeded target

* Result is based on information available at the time of this report. Final results will be released in December in a supplement to this annual report.



Notes:

1. Result is based on information available at the time of this report. Final expenditure figures may be adjusted as health authorities finalize their fiscal year end accounts.
2. The 2000/01 baseline was restated to 24.9% from 25.8%, which was published in the Ministry of Health Services' 2002/03 Service Plan. This change was a result of additional data being submitted to the ministry, plus changes resulting in consistency in the measurement of this indicator.
3. Administrative and support services expenditures include functional centres or departments for administration and support as defined by CIHI, plus functional centres for nursing inpatient services administration, ambulatory care and community services administration, to ensure consistency with ministry analysis this excludes systems support.

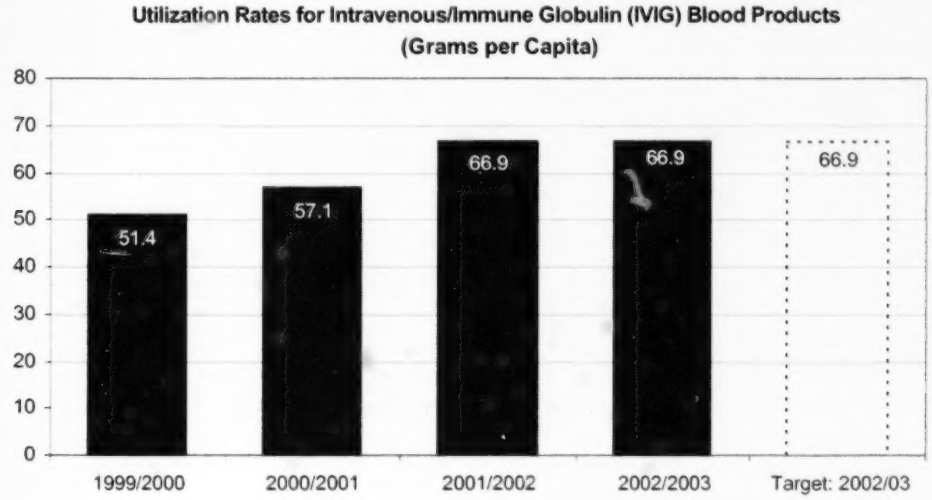
Source: Health Authority Management Information System, Information Support Branch.

Appropriate use of blood products for clinical purposes measured by utilization of Intravenous/Immune Globulin (IVIG) Blood Products (Goal 1: PM#5)

This indicator measures the use of intravenous immune globulin (IVIG), a blood product made from human plasma. This blood product is licensed for treating some clinical conditions. However, it is also being used for treating conditions not supported by medical research. The average cost of IVIG therapy is approximately $70 per gram and the cost per course of treatment regularly exceeds $10,000. Through the Provincial Blood Coordinating Office, the ministry has implemented an IVIG Utilization Management Project to monitor the use of IVIG with the goal of stabilizing and reducing use of this treatment option.

Results

2002/03 Target	2002/03 Actual	Status
Stable (at 66.9 grams per capita) Baseline: 2001/02	Stable	Met target



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Administrative and support services expenditures as a percentage of total expenditures, by health authority (Goal 1: PM#8)

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Results

2002/03 Target	2002/03 Preliminary*	Status*
Maintain 2000/01 percentage (24.9%) Baseline: 2000/01	Percentage decreased to 21.7%	Exceeded target

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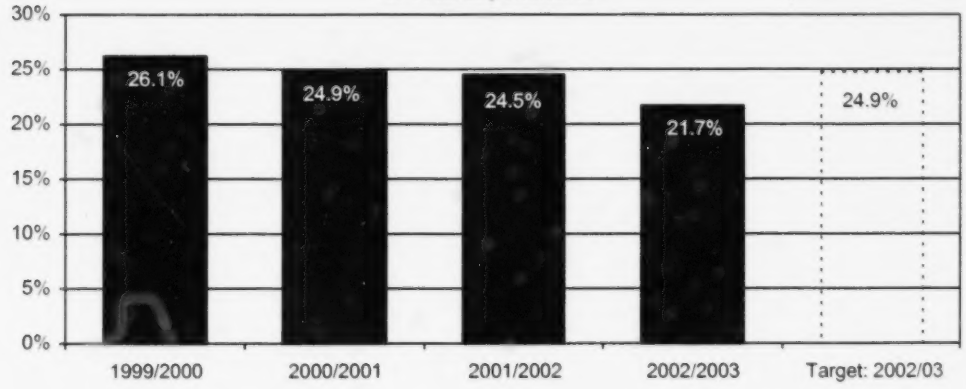
Health Authority Administrative and Support Expenditures as a Percentage of Total Expenditures



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Source: Health Authority Management Information System, Information Support Branch.

Goal 1: High Quality Patient-Centred Care	
Objective 3: Patients have equitable and timely access to health care services.	
Strategies:	
• Introduce strategies to improve access to basic health services (primary care).	Underway
• Modernize mental health care through the implementation of the Mental Health Plan.	Underway
• Commence implementation of a population needs-based funding formula to allocate resources to health authorities.	Completed
• Establish the Provincial Health Services Authority to reduce variability in access to specialized services across patient groups and place of residence.	Completed
• Work with the Ministry of Health Planning to implement the rural and remote health initiative.	Underway
• Expand the number of hospitals utilizing the PharmaNet system and BC BedLine.	Completed

Achievements:

- The Primary Health Care Renewal Project, designed to provide better access to services, has finished the initial planning phase. Health authority plans will be implemented in 2003/04. These include investment in professional and organizational development, a range of practice models including multi-disciplinary practice teams, physician collaboratives and other shared care approaches.
- A comprehensive mental health strategy was launched to: focus on early detection and evidence-based care; develop a permanent communications infrastructure to improve mental health literacy; better integrate mental health care throughout the health system; and focus on self-management and best practices.
- The Provincial Health Services Authority (PHSA) was established to ensure specialized services are delivered effectively throughout BC. It is currently developing a Provincial Perinatal Service, which will optimize care of high risk pregnant women and their infants across the province. PHSA is also working with health authorities to examine patients' needs, provincial capacity and management of wait lists, under the Cardiac Program.
- Programs such as the doctors' rural incentive agreement, rural specialist locum program, and expansion of medical school placements in regional universities encourage health professionals to live and work in rural BC.
- All acute care hospitals in BC are currently using the BC BedLine call centre to request help in transferring patients. The BC BedLine Web site is also being used by hospitals that regularly receive patient transfers. Thirty hospitals are reporting their bed availability every four hours on the Web site, and another 11 are sending daily verbal reports.

Performance Measures

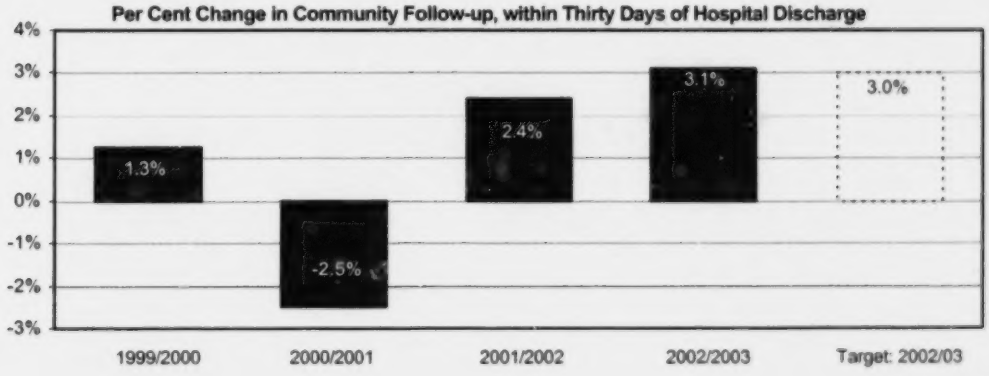
Improved continuity of care measured by the proportion of persons hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge (Goal 1: PM#4a)

This measures the percentage of persons aged 15–64 who have been hospitalized for a mental health illness and who receive at least one follow-up treatment at a community-based Mental Health Centre (MHC) or with a General Practitioner/Psychiatrist, within 30 days of being discharged from hospital. A high rate of community or physician follow-up indicates well-coordinated and accessible continuity of care for people with a mental health diagnosis.

Results

2002/03 Target	2002/03 Preliminary*	Status*
3% increase Baseline: 2000/01	3.1% increase	Met target

* Based on preliminary data to December 2002. Final results will be released in December in a supplement to this annual report.



Note: 2002/03 data are based on preliminary data to December 2002.

Source: Mental Health Data Warehouse and Discharge Abstracts Database, Information Support, BC Ministry of Health Services; MSP Claims.

Performance Measures

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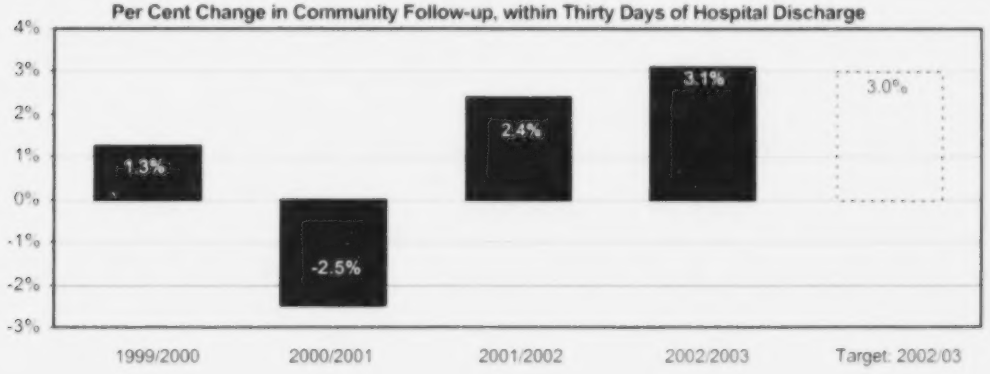
Results

2002/03 Target	2002/03 Preliminary*	Status*
3% increase Baseline: 2000/01	3.1% increase	Met target

* Based on preliminary data to December 2002. Final results will be released in December in a supplement to this annual report.



Note: 2002/03 data are based on preliminary data to December 2002.

Source: Mental Health Data Warehouse and Discharge Abstracts Database, Information Support, BC Ministry of Health Services; MSP Claims.

Improved availability of community services measured by percentage of days spent by mental health patients in hospitals after the need for hospital care ended
(Goal 1: PM#4bi)

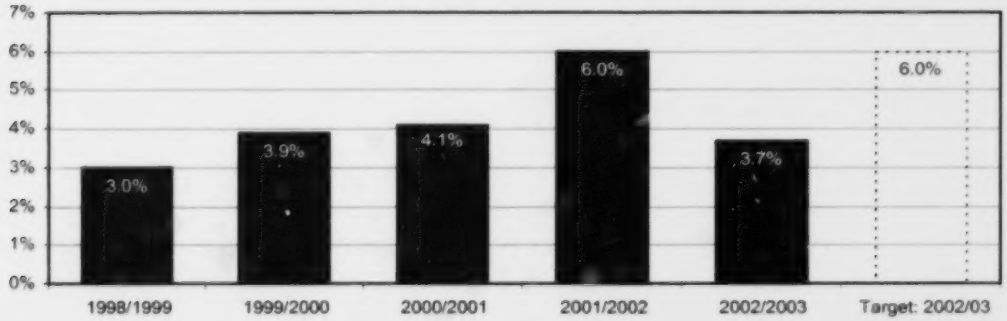
This measures the number of days that Alternate Level of Care (ALC) mental health patients spend in acute care hospitals, as a proportion of all in-patient hospital days. Note that this measure is the same as the previous ALC measure, but focuses on people who are hospitalized for a mental health diagnosis.

Results

2002/03 Target	2002/03 Preliminary*	Status*
No change (maintain or decrease rate below rate in baseline year) Baseline: 2001/02	Rate decreased	Exceeded target

* Based on preliminary data to December 2002. Final results will be released in December in a supplement to this annual report.

Alternate Level of Care (ALC) Days, as a Per Cent of Hospital In-patient Days for Patients Hospitalized for a Mental Health Diagnosis



For patients with a mental health diagnosis:	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003
ALC Days	6,720	8,858	9,467	13,896	5,040
Inpatient Days	226,042	227,818	231,847	232,198	135,544
ALC Rate Per Cent	3.0%	3.9%	4.1%	6.0%	3.7%

Notes:
1. 2002/03 data are based on preliminary data to December 2002.
2. Total inpatient days include acute care, rehabilitation and alternate level of care/discharge planning (no newborns).
3. For 1999/00 and later, ALC includes all days coded alternate level of care or discharge planning.
4. The data includes primary diagnosis and primary procedure only.

Source: Discharge Abstract Database, Information Support, Regional Programs, BC Ministry of Health

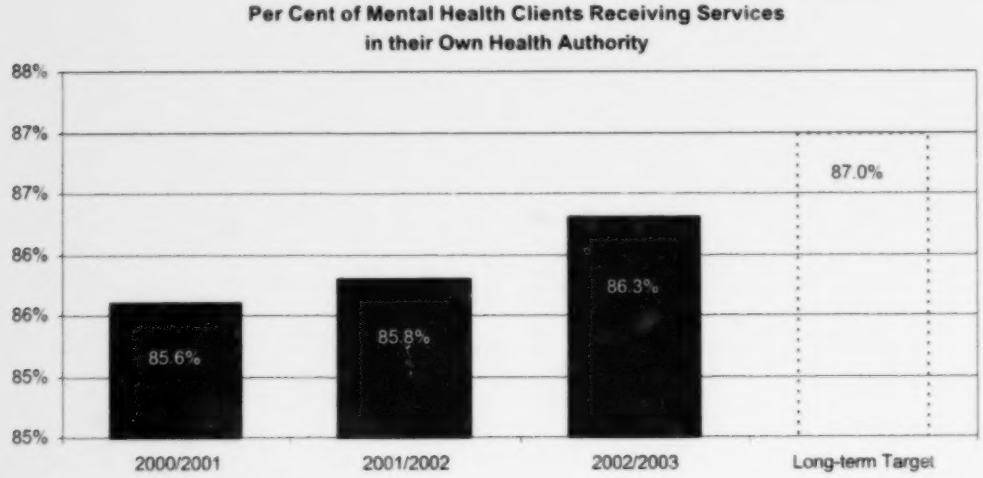
Percentage of mental health clients receiving services in their own region
(Goal 1: PM#4bii)

This measures the range of services that mental health clients receive in their own communities or regional health authorities. It indicates better access and greater availability of mental health care and community services for clients.

Results

2002/03 Target	2002/03 Preliminary*	Status*
Increase (above 85.8%) Baseline: 2001/02	Increased	Met target

* Based on partial data to January 2003. Final results will be released in December in a supplement to this annual report.



Note: 2002/03 data are based on preliminary data to January 2003.

Source: Mental Health Research Data Warehouse, Information Support, BC Ministry of Health Services.

Improved availability of community services measured by percentage of days spent by mental health patients in hospitals after the need for hospital care ended
(Goal 1: PM#4bi)

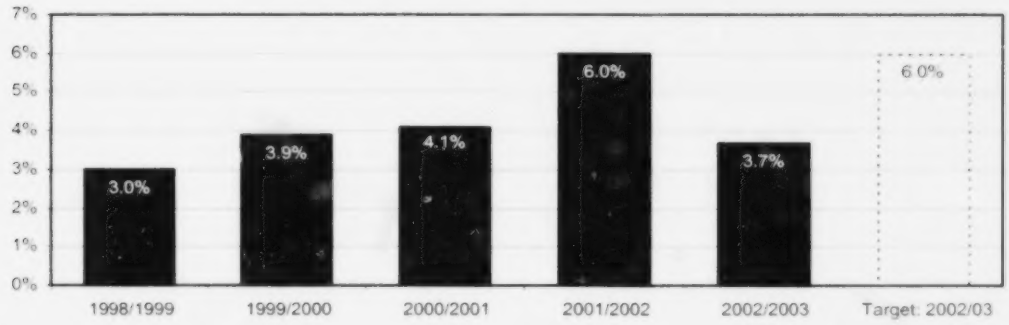
This measures the number of days that Alternate Level of Care (ALC) mental health patients spend in acute care hospitals, as a proportion of all in-patient hospital days. Note that this measure is the same as the previous ALC measure, but focuses on people who are hospitalized for a mental health diagnosis.

Results

2002/03 Target	2002/03 Preliminary*	Status*
No change (maintain or decrease rate below rate in baseline year) Baseline: 2001/02	Rate decreased	Exceeded target

* Based on preliminary data to December 2002. Final results will be released in December in a supplement to this annual report.

Alternate Level of Care (ALC) Days, as a Per Cent of Hospital In-patient Days for Patients Hospitalized for a Mental Health Diagnosis



For patients with a mental health diagnosis:	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003
ALC Days	6,720	8,858	9,467	13,896	5,040
Inpatient Days	226,042	227,818	231,847	232,198	135,544
ALC Rate Per Cent	3.0%	3.9%	4.1%	6.0%	3.7%

Notes:

1. 2002/03 data are based on preliminary data to December 2002.
2. Total inpatient days include acute care, rehabilitation and alternate level of care/discharge planning (no newborns).
3. For 1999/00 and later, ALC includes all days coded alternate level of care or discharge planning.
4. The data includes primary diagnosis and primary procedure only.

Source: Discharge Abstract Database, Information Support, Regional Programs, BC Ministry of Health

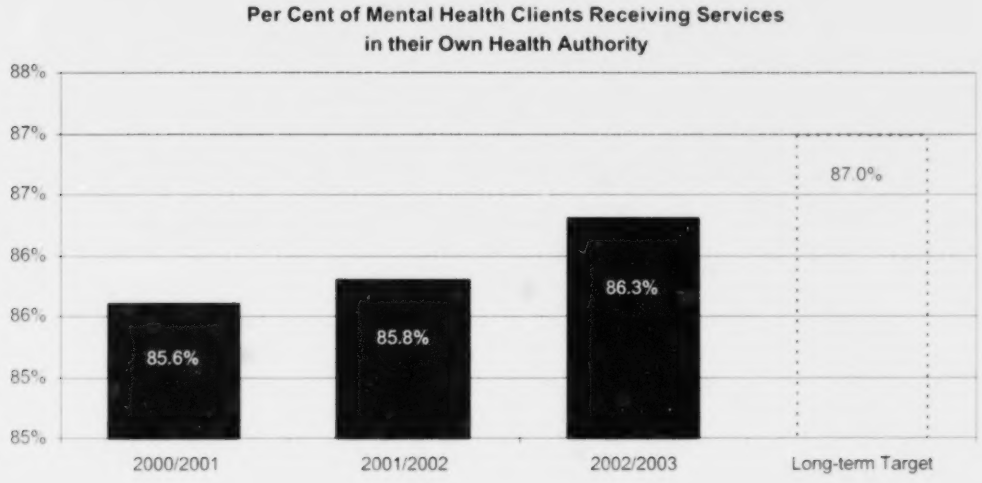
Percentage of mental health clients receiving services in their own region
(Goal 1: PM#4bii)

This measures the range of services that mental health clients receive in their own communities or regional health authorities. It indicates better access and greater availability of mental health care and community services for clients.

Results

2002/03 Target	2002/03 Preliminary*	Status*
Increase (above 85.8%) Baseline: 2001/02	Increased	Met target

* Based on partial data to January 2003. Final results will be released in December in a supplement to this annual report.



Note: 2002/03 data are based on preliminary data to January 2003.

Source: Mental Health Research Data Warehouse, Information Support, BC Ministry of Health Services.

Proportion of mental health clients accessing community services (Goal 1: PM#4biii)

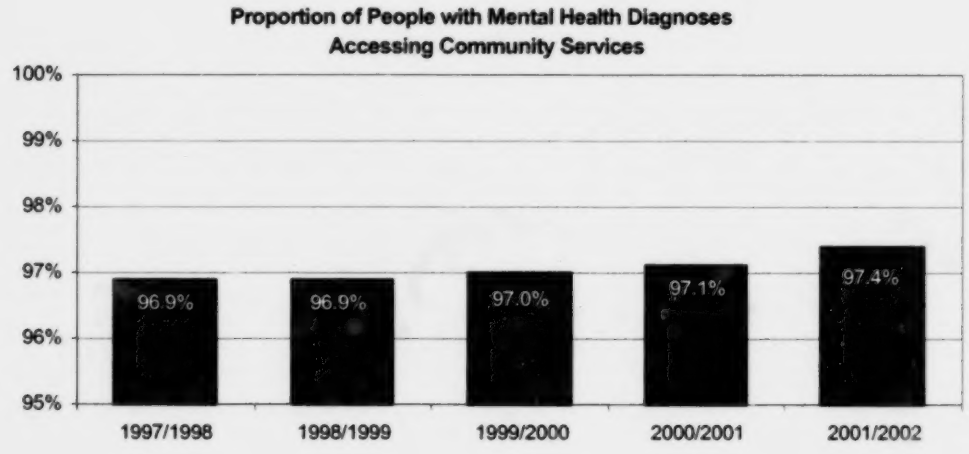
This indicator shows the availability of community services by measuring the percentage of people with a mental disorder who have received at least one mental health service from a care provider or health centre in the community.

Over the past five years, an increasing proportion of clients with mental illnesses are receiving care through community-based services — at a mental health centre, a physician's office or both.

Results

2002/03 Target	2002/03 Actual	Status
Increase Baseline: 2000/01	Data not yet available	Pending*

* Final results or data for 2002/03 will be released in December in a supplement to this annual report.



Source: Mental Health Research Data Warehouse, Information Support, BC Ministry of Health Services.

Waiting times for key services — Radiotherapy and Chemotherapy (Goal 1: PM#6a)

Monitoring wait times helps ensure patients' cancers are treated as early as possible to achieve the best outcomes. This indicator measures the percentage of patients that begin radiotherapy within four weeks of being ready to treat and the percentage of patients who start chemotherapy within two weeks of being ready to treat. The measurement is based on median wait times for these services and the number of patients treated.

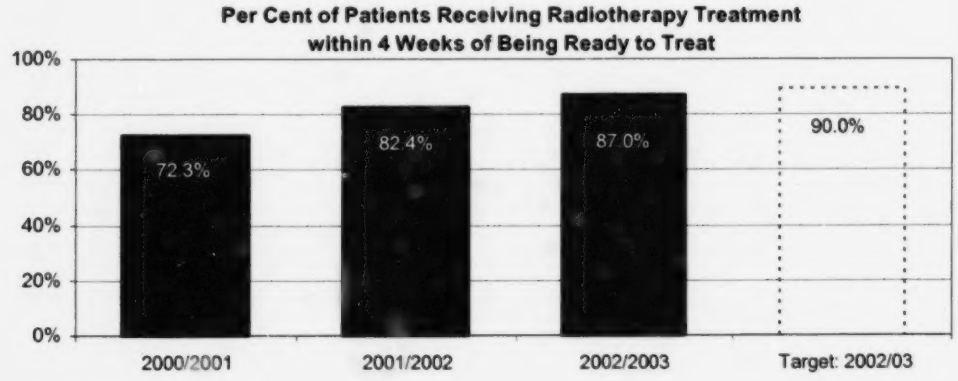
As of March 2003, 87 per cent of patients requiring radiotherapy started treatment within four weeks of being ready to treat, slightly below the target of 90 per cent. The 2002/03 target value was set based on inaccurate baseline data for 2001/02, which estimated radiotherapy treatment at 88 per cent in that year when it was actually 82 per cent. Although the 2002/03 treatment rate remains below the 90 per cent target, results show a significant and steady improvement over 2000/01, when only 72 per cent of patients began treatment within four weeks. For chemotherapy, consistently, the BC Cancer Agency reports that over 90 per cent of patients receive treatment within two weeks.

The expansion of the Victoria Cancer Clinic provides more radiotherapy services in BC to meet the increasing demand for these services. Planning for a new clinic in Abbotsford will help ensure provincial services keep up with the growing incidence of cancer.

Results

2002/03 Target	2002/03 Actual	Status
Radiotherapy: 90% of patients begin treatment within 4 weeks of being ready to treat	Radiotherapy: 87% of patients began treatment within 4 weeks of being ready to treat	Missed target*
Chemotherapy: 90% of patients begin treatment within 2 weeks of being ready to treat	Chemotherapy: Over 90% of patients began treatment within 2 weeks of being ready to treat	Met target

* See discussion above for an explanation of the variance.



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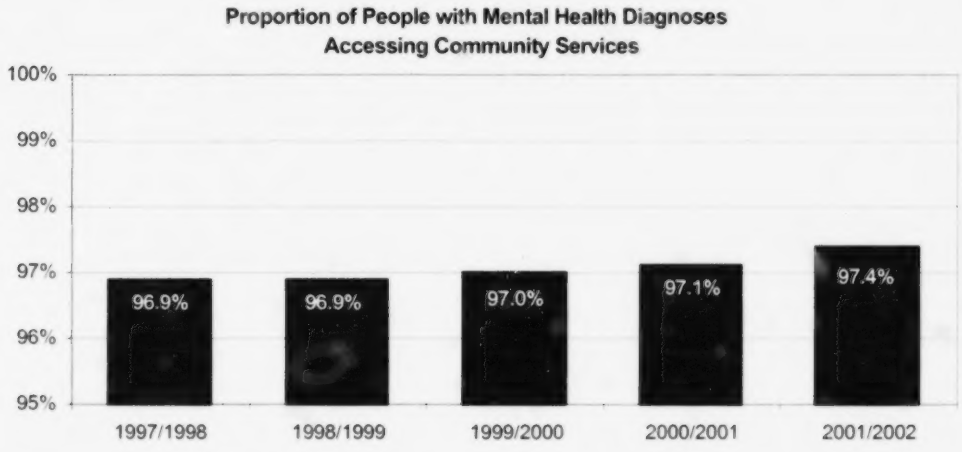

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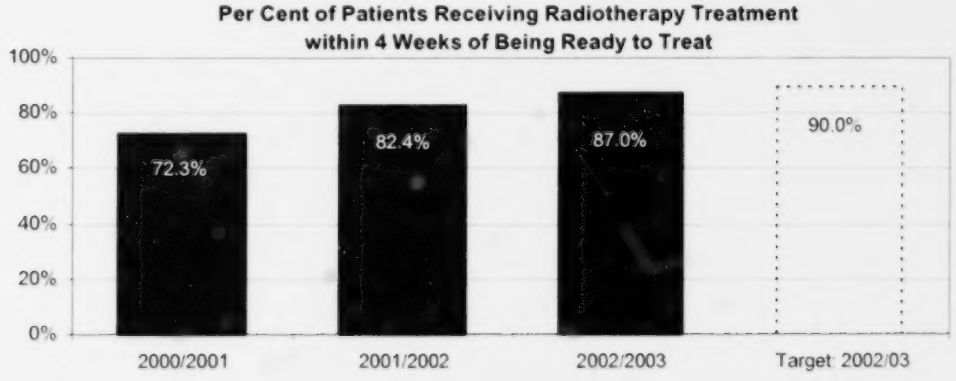


Source: BC Cancer Agency

Regional variation in access to selected services (Goal 1: PM#7)

Measuring regional rates for major surgical procedures helps compare access to services among health authorities (HA): the wider the variation, the greater the inequities in accessing services across health authorities. This indicator specifically measures utilization rates of hip, knee and cardiac surgeries for regions. Comparative data for 2002/03 showing variations across BC's regions will be available in December 2003.

Results

2002/03 Target	2002/03 Actual	Status
Reduce variation in regional differences to access services by 10% Baseline: 2001/02	Data for hip, knee and cardiac surgeries will not be available for 2002/03 until December 2003	Pending*

* Final results will be released in December in a supplement to this annual report.

	Hip Replacement Surgeries		Knee Replacement Surgeries		Coronary Artery Bypass Surgeries	
	2001/02 HA Range	2002/03 Target Range	2001/02 HA Range	2002/03 Target Range	2001/02 HA Range	2002/03 Target Range
Range in Surgery Rates Across Health Authorities (cases per 1,000 population)	30.7	27.6	52.0	46.8	19.0	17.1

Notes:

1. The surgery and procedure rates are per 100,000 age-adjusted population in the health authority.
2. Residents of BC treated out-of-province are included. BC non-residents are excluded.

Source: Discharge Abstract Database, Information Support, Ministry of Health Services.

24/7 access to basic health services (primary care) (Goal 1: PM#10)

24/7 access to services is vital to improving primary health care and building a patient-centred health system in BC. Usage rates for the BC NurseLine indicate access to skilled care providers — to specially trained registered nurses — by telephone, anytime of the day or night, across the province. Further, the practice among many physicians is to direct their patients to hospital emergency departments after hours. The NurseLine provides an alternative for obtaining an objective assessment of patients' problems.

Results

2002/03 Target	2002/03 Actual	Status
25% increase in NurseLine use	43% increase in NurseLine use	Exceeded target
15% increase in after hour call-forwarding from physician offices to NurseLine Baseline: 2001/02	203% increase in after hour call-forwarding from physician offices to NurseLine	Exceeded target

Number of Calls to the NurseLine		Number of Times Physicians Call Forwarded After Hours to the NurseLine	
2001/02	99,497	2001/02	335 (revised 01/02)
2002/03	142,142	2002/03	1,015

Source: BC Ministry of Health Services

Goal 1: High Quality Patient-Centred Care	
Objective 4: Patient satisfaction and public confidence in the system are increased.	
Strategies:	
• Implement an annual mental health report card.	Underway
• Increase access to information to help patients and their families understand and manage their health through the self-care project, the NurseLine and other patient self-care approaches.	Completed

Achievements:

- BC HealthGuide Program: Since April 2001, over 1.8 million books have been distributed to households, health professionals, and health related agencies in BC; more than 1,000,000 hits have been made to BC HealthGuide OnLine; and 27,000 BC First Nations Health Handbooks were distributed to aboriginal communities throughout BC.
- BC NurseLine: Since opening, the BC NurseLine has provided health information and advice to over 240,000 callers.
- Through the Provincial Chronic Disease Strategy, the province gives the public and service providers Web-based access to information and tools to manage chronic diseases.

Performance Measures

Public satisfaction rates (Goal 1: PM#9)

This indicator measures peoples' level of satisfaction with health services in general and with services received in a hospital, doctor's office or community centre. This information helps identify improvements from the patient's perspective, and consequently supports system accountability and a shift towards a patient-centered health system.

Original targets were selected based on a 2001 Leger Survey[1]. This survey indicated that 56.6 per cent of Canadians were satisfied with the health system, compared with 41.1 per cent of respondents who were not satisfied. In BC, 46.6 per cent of respondents were satisfied with the health system. The Leger Survey has not been repeated.

The recently released 2003 Aventis Healthcare Survey, which surveyed 1,500 people with employer-sponsored health plans, found that 23 per cent of respondents said the health care system was excellent/very good and a further 58 per cent said it was good. Comparable figures at the national level were 30 per cent and 52 per cent respectively.

Results

2002/03 Target	2002/03 Actual	Status
Maintain public satisfaction levels at current rate of 45 – 50% satisfied with the way health services are provided	Comparable 2002 data not available Similar data show: 23% rate health care system as excellent/good 58% rate health care system as good	Met target

Source: The 2003 Aventis Healthcare Survey; Research, Rogers Healthcare and Financial Services Group.

[1] Leger Marketing surveyed 1,507 Canadians between June 5 and 13, 2001; the results are considered accurate within 2.6% points, 19 out of 20.

Goal 2: Improved Health and Wellness for British Columbians	
Objective 1: Reduce occurrence of preventable illness and disability.	
Strategies:	
• Deliver effective strategies to prevent or delay onset of selected illnesses and injuries.	Underway
• Ensure compliance with and enforcement of health regulations that protect the health of the public.	Ongoing

Achievements:

- A chronic disease prevention framework has been disseminated to stakeholders. The goal is to develop and prioritize actions and interventions based on their potential to reduce the burden of disease. For example, targeting unhealthy eating habits can lead to lower rates of heart disease. The ministry has formed a Provincial Chronic Disease Prevention Alliance to enhance integration and collaboration, and has started drafting evidence papers to track interventions for their potential to reduce the burden of disease. This is in addition to clinical guidelines and protocols, the chronic disease Web site, patient registries and other programs developed under BC's Chronic Disease Management Strategy.
- The Ministry of Health Planning, the BC Centre for Disease Control, and the health authorities have drafted a pandemic influenza preparedness plan.
- The ministries announced funding for two additional vaccines to help prevent ear infections, pneumonia, bacteremia, meningitis and bacterial meningitis.
- A comprehensive $16-million action plan to strengthen drinking water protection was approved by Cabinet in June 2002. This action plan will increase source protection, monitoring assessments and infrastructure investment.
- The *Community Care and Assisted Living Act* was passed. This will modernize the regulation of community and child-care facilities to protect the health and safety of vulnerable children, youth and adults.

Performance Measures

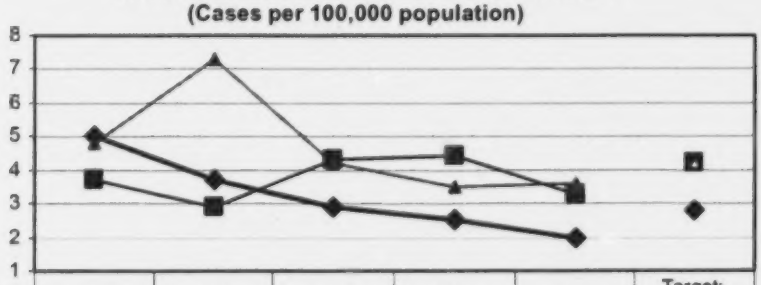
Incidence of selected communicable diseases (Acute hepatitis B; Cryptosporidiosis; and E.coli 0157) (Goal 2: PM#1)

These indicators measure the success of provincial health programs in preventing and controlling selected communicable diseases.

Results

Measure	2002 Target	2002 Actual	Status
Incidence of: Acute hepatitis B	2.6 cases per 100,000 population	1.8 cases per 100,000 population (2002)	Exceeded target
Incidence of: Cryptosporidiosis (a measure of drinking water quality)	4 cases per 100,000 population	3.1 cases per 100,000 population (2002)	Exceeded target
Incidence of: E.coli 0157 (a measure of food safety)	Rate to remain below 4 cases per 100,000 population	3.4 cases per 100,000 population (2002)	Exceeded target
Baseline: 2000			

Incidence of Selected Communicable Diseases
(Cases per 100,000 population)



	1998	1999	2000	2001	2002	Target: 2002
Acute Hepatitis B	4.8	3.5	2.7	2.3	1.8	2.6
Cryptosporidiosis	3.5	2.7	4.1	4.2	3.1	4.0
E. coli	4.6	7.1	4.0	3.3	3.4	4.0

Source: Epidemiology Services, BC Centre for Disease Control.

Potential Years of Life Lost (PYLL) due to cancer, heart disease, and injuries
(Goal 2: PM#2)

This indicator measures Potential Years of Life Lost (PYLL) for selected causes, expressed as age-standardized rates per 1,000 standard population. PYLL is the number of years of life "lost" when a person dies before an established cut-off point, in this case, age 75. It focuses on premature deaths — deaths that occur in the younger age groups and that can, in theory, be prevented or at least postponed. PYLL is a generally accepted, overall indicator of population health and is a good measure of the effectiveness of prevention programs.

Cardiovascular disease, cancer, and injuries (external causes) have been selected because they account for approximately two-thirds of total PYLL (cardiovascular disease: 15%, cancer: 30%, injuries: 22%).

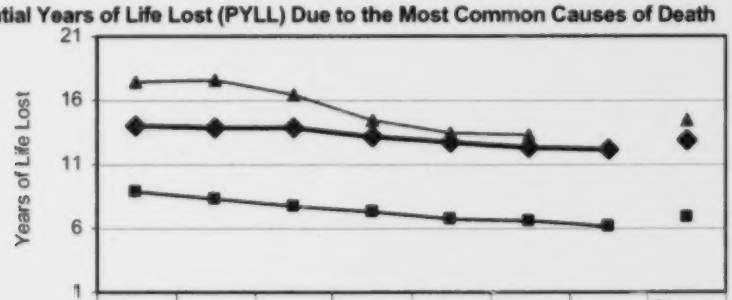
Note: The 2002 rate for injuries (external causes) is not yet available as these deaths are subject to coroner review and may require lengthy investigations before a final cause of death is determined.

Results

Measure	2002 Target	2002 Actual	Status
PYLL due to cancer	12.6 PYLL per 1,000 population	11.9 PYLL per 1,000 population (2002)	Exceeded target
PYLL due to cardio-vascular (heart) disease	6.7 PYLL per 1,000 population	5.9 PYLL per 1,000 population	Exceeded target
PYLL due to injuries	14.3 PYLL per 1,000 population	Data not available until Fall 2003	Pending*

* Final results will be released in December in a supplement to this annual report.

Potential Years of Life Lost (PYLL) Due to the Most Common Causes of Death



	1996	1997	1998	1999	2000	2001	2002	Target: 2002
Cancer	13.8	13.7	13.6	12.9	12.5	12.1	11.9	12.6
Cardiovascular Disease	8.7	8.1	7.5	7.1	6.5	6.4	5.9	6.7
External Causes (Injuries)	17.3	17.4	16.3	14.3	13.3	13.1		14.3

Note: Potential Years of Life Lost Rate (PYLLSR) per 1,000 Standard population (Canada Census 1991). Data for 2002 for external causes are not yet available.

Source: BC Vital Statistics Agency

Immunization rates — 2 year olds with up-to-date immunizations (Goal 2: PM#3a)

This indicator measures the effectiveness and use of immunization programs. Low rates may indicate a problem in access or delivery of these services. Immunization programs for children remain among the most cost-effective ways to improve health status and reduce health care costs. In BC, all infants and preschool children have access to immunizations, protecting them from the following nine serious diseases: diphtheria, tetanus, polio, pertussis, haemophilus influenza type b, mumps, measles, rubella, and hepatitis B. (The hepatitis B immunization program was implemented in 2001; data is not yet available for this age group).

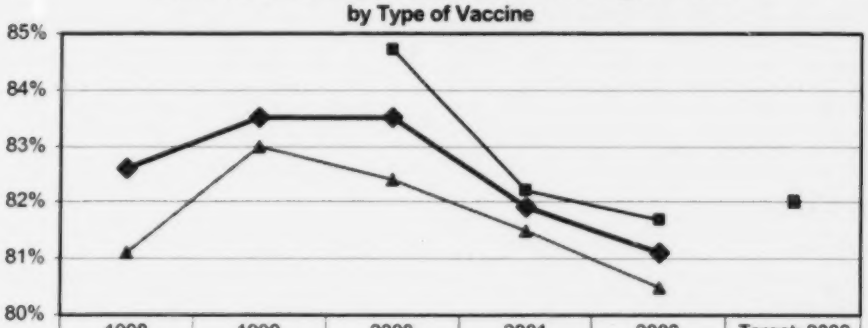
In 2001, about half of health regions estimated that over 80 per cent of children had been fully immunized by their second birthday. In BC, while these programs are publicly funded, the reported immunization rates for two-year-olds, while relatively stable in recent years, show a slight decline for the second year in a row. The reason for the decline is not known, but factors that can influence immunization rates include concerns over the efficacy and safety of vaccines and the perception certain diseases are rare and no longer pose a threat to public health. The ministry will be working with the BC Centre for Disease Control and health authorities to examine the data and to ensure the decline in immunization rates does not become a trend.

Note: For some areas of the province, immunization statistics remain unavailable due to various data collection and retrieval issues. The Ministry of Health Planning is reviewing methods to support improved data reporting to improve accuracy.

Results

2002 Target	2002 Actual	Status
82%	DPTP: 81.1% Hib: 81.7% MMR/MR 80.5%	Missed target

Estimated Immunization Rates for Children Aged 2 Years by Type of Vaccine



	1998	1999	2000	2001	2002	Target: 2002
DPTP	82.6%	83.5%	83.5%	81.9%	81.1%	82.0%
Hib	—	—	84.7%	82.2%	81.7%	82.0%
MMR/MR	81.1%	83.0%	82.4%	81.5%	80.5%	82.0%

Notes:
1. Complete data were not available for Fraser and Vancouver Coastal Health Authorities.
2. Statistics are determined from an audit of a one-month sample of Child Health Records, done in April of each year.
3. MMR/MR = Measles Mumps Rubella or Measles Rubelia (2 doses).
4. DPTP = Diphtheria Pertussis Tetanus Polio (4 doses).
5. Hib = Haemophilus Influenza b (4 doses).

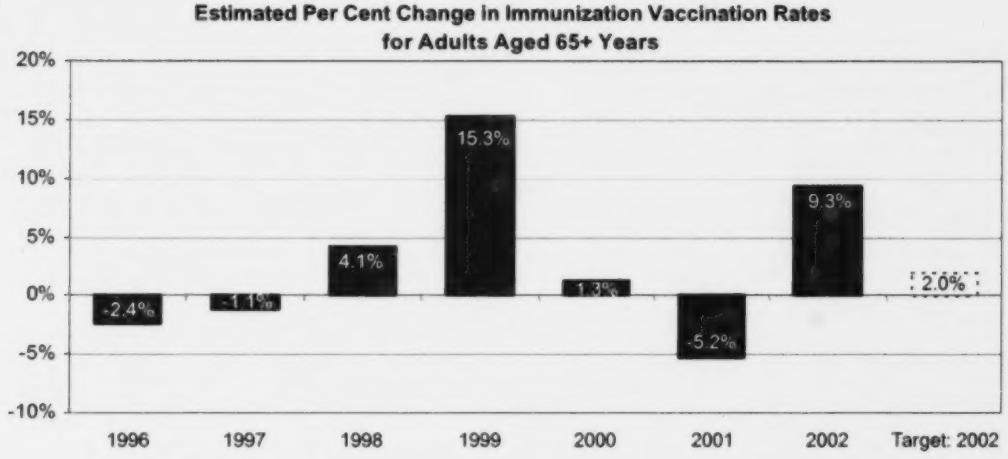
Source: Disease and Injury Prevention Branch, Ministry of Health Services.

Immunization rates — Influenza vaccination, population age 65 and over
(Goal 2: PM#3b)

This indicator measures immunization rates for influenza vaccination for persons 65 years of age and older. Influenza is a major cause of illness, hospitalization and death among older adults. Annual influenza vaccination reduces the risk of disease and may lessen the severity of illness. It is also effective preparation for an influenza pandemic, anticipated within the next five to ten years. Full implementation of the immunization program — with immunization of 80 per cent of adults age 65 and older — could prevent half of the deaths, hospitalizations and physician visits for influenza.

Results

2002 Target	2002 Actual	Status
2% increase Baseline: 2001	9.3% increase	Exceeded target



	1995	1996	1997	1998	1999	2000	2001	2002
Influenza Vaccination Rate (65+)	55.2%	53.9%	53.3%	55.5%	64.0%	64.8%	61.4%	67.1%

Note: Data not available for 2002 for Northern Health Authority. Final results will be released in December in a supplement to this annual report. Prior to 2000, data excludes Vancouver and Capital health regions.

Source: Disease and Injury Prevention Branch, Ministry of Health Services.

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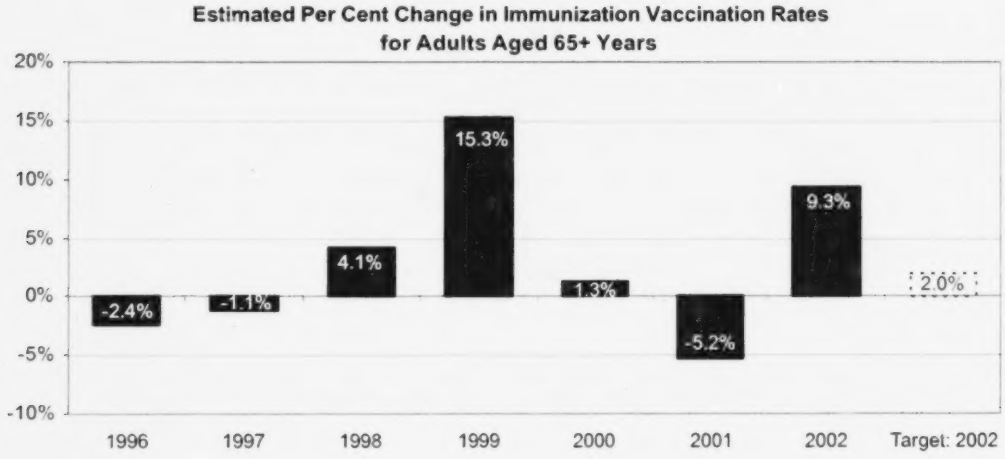

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Utilization of screening programs for at risk groups (screening mammography)
(Goal 2: PM#4)

This indicator measures the use of mammograms to screen 50- to 74-year-old women every two years for cancer. It is calculated as the number of women being screened at least once at a screening mammography program facility (SMPBC), divided by the female population in that age group. Screening mammography is an important service for the early detection of illness, and reaching a larger proportion of the population is important in improving population health. The estimated biannual screening rate increased to 51 per cent in 2001/02. Data for this measure is not yet available for 2002/03.

Results

2002 Target	2002 Actual	Status
53%*	Data for this measure is not available for 2002/03.	Pending**

* The 2002/03 target has been adjusted from the original target value of 58%, published in the 2002/03 Service Plan, as the original value was based in part on an estimate of Medical Service Plan volume levels for diagnostic services provided to women (an estimated 10% of women receive diagnostic services biannually). As this measure is intended to capture participation levels in the screening mammography program alone, diagnostic services have now been removed from the calculation of this measure. The original target value has been accordingly prorated by 10% to arrive at the revised screening mammography program's target value of 53%.

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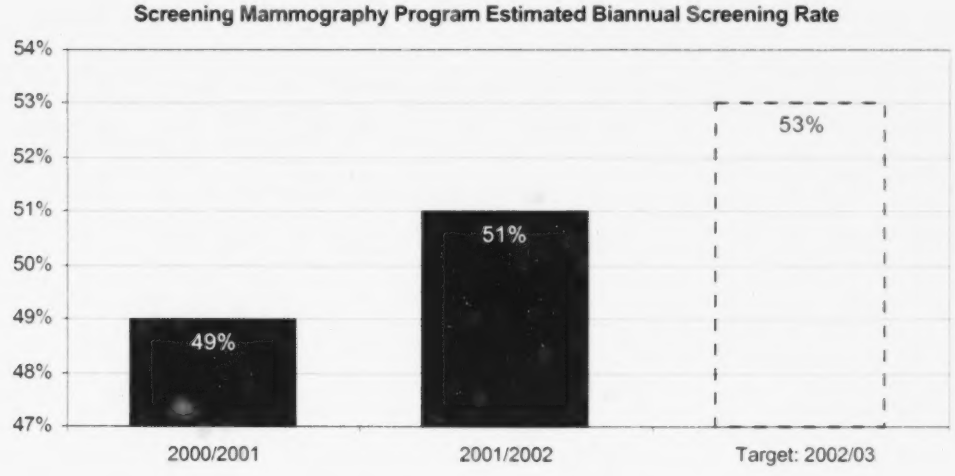

Note: Screening Mammography Program (SMP) data extracted in August 2002.

Source: SMPBC Trends, Health Data Warehouse; Population data: BC Stats and Health Data Warehouse.

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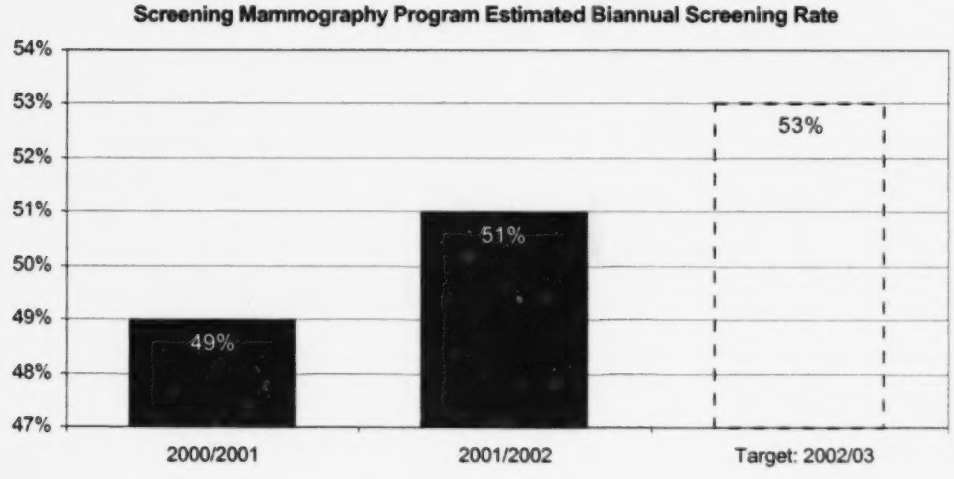

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Source: SMPBC Trends, Health Data Warehouse; Population data: BC Stats and Health Data Warehouse.

Goal 2: Improved Health and Wellness for British Columbians	
Objective 2: Reduce inequalities in health status among specific populations in British Columbia.	
Strategies:	
• Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care.	Underway
• Support initiatives to improve the health status of people with mental illnesses.	Underway

Achievements:

- The Ministry of Health Planning is working with Aboriginal health stakeholders to develop a Provincial Aboriginal Health Services Strategy (PAHSS). This work will contribute to Aboriginal health by increasing access to appropriate health services, by enhancing participating of Aboriginal people in decision making and by promoting better integration of Aboriginal specific care with mainstream health care services and programs.
- *Honouring Our Health — An Aboriginal Tobacco Strategy for BC* was released in 2001. It is the first of its kind in Canada and is currently being evaluated.
- Health authorities have completed Aboriginal Health Plans for each region, working with Aboriginal communities and organizations.
- The province is working with federal and First Nations agencies to develop a comprehensive Aboriginal health database to identify population, incidence of chronic diseases and access to standardized treatment resources or protocols.
- The province has distributed an Aboriginal Health Care Service Provider Manual and First Nations Companion Handbook to the BC HealthGuide.
- A comprehensive mental health strategy was launched to focus on: early detection and evidence-based care; develop a permanent communications infrastructure to improve mental health literacy; better integrate mental health care throughout the health system; and focus on self-management and clinical practice guidelines.

Performance Measures

Improved health status for Aboriginal peoples measured by infant mortality and life expectancy (Goal 2: PM#7)

These indicators measure infant mortality and life expectancy rates for Aboriginal peoples. As a group, Aboriginal peoples have a level of health below that of the general population.

Infant Mortality Rate: The infant mortality rate for the Aboriginal status Indian population in the province moved from a high of 15.4 to a low of 4.0 during 1991 to 2001. The 2001 rate of 4.3 infant deaths per 1,000 live births was only slightly higher than the overall provincial rate of 4.0. Although, the gap has remained relatively stable for the past three years, this is a vast improvement over rates that were more than double the provincial rate in the early 1990s. 2002 infant mortality rates data for Aboriginal peoples is not yet available.

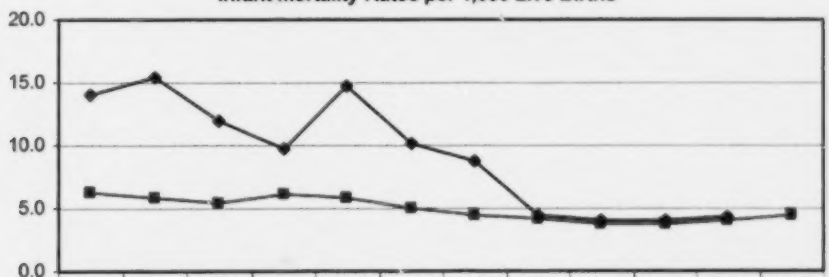
Life Expectancy: For British Columbians, life expectancy (five-year average) has risen steadily in the last decade from 78.6 to 79.9 in the general population, and from 69.8 to 72.7 in the status Indian population. Although still less than the general population, the gap in life expectancy between the status Indian and general population has decreased slightly in the last decade.

Results

2002/03 Target	2002 Actual	Status
Improvement in Status Indian infant mortality.	Infant mortality per 1,000 live births in 2002: Aboriginals: N/A Total BC population: 4.4 per 1,000	Pending*
Improvement in Status Indian life expectancy, from 1991-1999 baseline.	Life expectancy in 2002: Aboriginals: N/A Total BC population: 80.2 years	Pending*

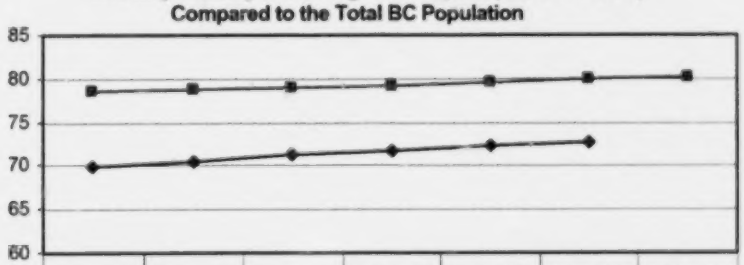
* 2002 data for Aboriginal peoples are not yet available. Final results will be released in December in a supplement to this annual report.

Infant Mortality Rates per 1,000 Live Births



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total BC population	6.3	5.9	5.4	6.1	5.9	5.0	4.5	4.1	3.8	3.7	4.0	4.4
Aboriginal (Status Indian)	14.0	15.4	11.9	9.7	14.7	10.2	8.8	4.5	4.0	4.0	4.3	

Life Expectancy of Aboriginal Peoples (Status Indian) Compared to the Total BC Population



	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001	1998-2002
Total BC population	78.6	78.8	79.0	79.2	79.5	79.9	80.2
Aboriginal (Status Indian)	69.8	70.5	71.2	71.7	72.3	72.7	

Note: 2002 infant mortality and life expectancy data for Aboriginal peoples are not yet available.

Source: BC Vital Statistics Agency, BC Stats.

Goal 2: Improved Health and Wellness for British Columbians	
Objective 3: People have the information they need to stay healthy.	
Strategies: • Promote behaviors that decrease people's risk of preventable illness.	Underway

Achievements:

- BC's Tobacco Control Strategy with performance indicators completed and approved, in principle, by the Minister. It includes a three-part approach: legislation and legal action to hold the industry accountable for its actions; prevention, cessation and enforcement programs; and public education.
- Under the Chronic Disease Prevention Strategy, the ministry has formed a Provincial Chronic Disease Alliance and started drafting evidence papers to track results of actions and interventions, thereby evaluating their potential to reduce the burden of disease.
- Under the BC HealthGuide Program, since April 2001, over 1.8 million books have been distributed; more than 1,000,000 hits have been made to BC HealthGuide OnLine; and 27,000 BC First Nations Health Handbooks have been distributed to Aboriginal communities throughout BC.
- Since opening, the BC NurseLine has provided health information and advice to over 240,000 callers.
- Through the Provincial Chronic Disease Strategy, the province provides Web-based access to information and tools for managing chronic diseases.
- Action Schools! BC is an interministerial and community-based initiative to promote physical activity among children and youth in schools and through public education. A Web site and resources have been developed as part of this project.

Performance Measures

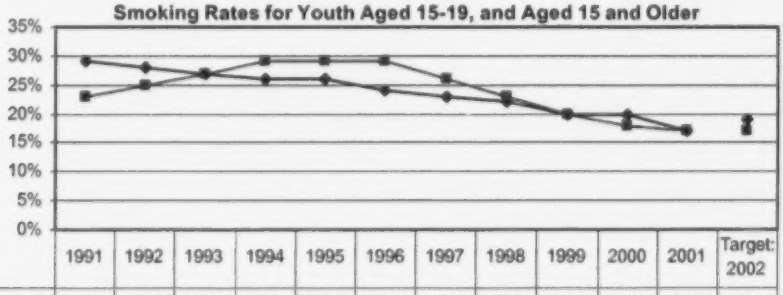
Smoking rates (measured every 2 years) (Goal 2: PM#5)

This indicator measures the proportion of the population who are current smokers (those who smoke cigarettes on either a daily or occasional basis). Smoking is the most frequent cause of lung cancer and chronic respiratory disease, and also increases the risk of coronary heart disease, stroke, and Sudden Infant Death Syndrome (SIDS). The rate of smoking in BC is currently the lowest in Canada for the general population aged 15 years and older. Rates have been dropping since 1994, suggesting that provincial programs to reduce smoking have been effective.

Results

2002/03 Target	2003 Actual	Status
Smoking Rates for Adults Reduce smoking prevalence by 1% from 2000 baseline to 19% for population age 15 and older	Full year data not yet available for 2002	Pending*
Smoking Rates for Youth Reduce smoking prevalence by 1% from 2000 baseline to 17% for youth age 15 – 19	Full year data not yet available for 2002	Pending*

* Final results will be released in December in a supplement to this annual report.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Target: 2002
Youth Aged 15-19	23%	25%	27%	29%	29%	29%	26%	23%	20%	18%	17%	17%
Aged 15 and older	29%	28%	27%	26%	26%	24%	23%	22%	20%	20%	17%	19%

Notes:
1. Includes daily and occasional smoking.
2. Rates for ages 15 – 19 in earlier years are based on very small sample sizes and are less reliable.
3. National Population Health Survey (NPHS) and Angus Reid data are for ages 12 +.

Source: Data for 1991: Statistics Canada, General Social Survey (GSS). Data for 1994, 1996, and 1998: Statistics Canada, NPHS. Data for 1999 to 2000: Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS).

Rates of healthy behaviors and conditions (Goal 2: PM#6)

Physically Active: Percentage of population age 12 and older physically active enough to attain health benefits (measured every 2 years).

Body Mass Index: Rates of healthy behaviors and conditions — percentage of adults with a healthy body weight (measured every 2 years).

This indicator measures the percentage of the population who have an acceptable body weight and are physically active. Body Mass Index (BMI) is an indicator of obesity and therefore an indicator of risk for chronic disease in the adult population, particularly heart disease and diabetes. (Healthy body weight is defined as a Body Mass Index between 20.0 and 24.9.) Physical inactivity is also a risk factor and indicator of population risk for future chronic illness, such as heart disease, diabetes, and some cancers.

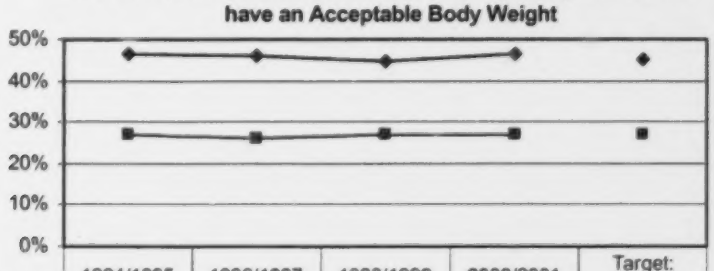
Data for these measures will be collected every two years through the Canadian Community Health Survey. 2002/03 data will be available next fall.

Results

2002/03 Target	2002/03 Actual	Status
Physically Active: Maintain at 27%	Data not yet available for 2002/03	Pending*
BMI: Maintain at 45%	Data not yet available for 2002/03	Pending*

*Final results will be released in December in a supplement to this annual report.

Per Cent of British Columbians who are Physically Active and have an Acceptable Body Weight



	1994/1995	1996/1997	1998/1999	2000/2001	Target: 2002/03
Physically Active	27.2%	26.2%	27.1%	26.9%	27.0%
Acceptable Body Weight	46.4%	45.9%	44.9%	46.4%	45.0%

Notes:

1. Data are from the National Population Health Survey for 1994/95, 1996/97 and 1998/99; data from Canadian Community Health Survey for 2000/01.
2. Acceptable body weight means a Body Mass Index of 20.0 - 24.9 for people aged 20 - 64 years (excluding pregnant women).
3. Physically active is based on response to questions about the frequency, duration, and intensity of participation in leisure time physical activity, for people aged 12+ years.

Source: Disease and Injury Prevention Branch

Goal 3: A Sustainable, Affordable Public Health System	
Objective 1: Invest in maintaining health in order to avoid higher costs in the future.	
Strategies:	
• Reduce the incidence of preventable conditions through targeted prevention programs based on a business case.	Underway
• Introduce more modern and cost-effective strategies for patient care to reduce complications and unnecessary health services.	Underway

Achievements:

- Under the Chronic Disease Prevention Strategy, the ministry has formed a Provincial Chronic Disease Alliance and started drafting evidence papers to track results of actions and interventions, thereby evaluating their potential to reduce the burden of disease.
- Evidence-based business cases have been developed for diabetes and congestive heart failure, and clearly show that better chronic care is critical to improving patient health status and sustaining the health care system.
- The government announced funding for conjugate pneumococcal vaccine and conjugate meningococcal group C vaccine. These vaccines are being introduced to higher risk population groups in April 2003, and will be integrated into the routine childhood immunization programs in July and September 2003.

Performance Measures

Cross program patient costs (e.g. diabetes) (Goal 3: PM#1)

This indicator measures the health care cost of patients with diabetes. Diabetes is a chronic disease that affects about five per cent of Canadians, and its prevalence is expected to increase significantly due to an aging population and increased rates of obesity.

Costs for people with diabetes were calculated for 2000/01 using the MSP, hospital and PharmaCare databases. Specifically, in 2000/01, total health costs for the 174,800 patients on the Diabetes Registry amounted to $663 million.

Results

2002/03 Target	2002/03 Actual	Status
For Diabetes: Develop 2000/01 baseline and targets for 2003/04 and 2004/05	Baseline established	Strategy revised in subsequent service plan

Because this performance measure cannot account for fixed cost due to its sensitivity to inflation and fixed cost drivers, this is not the best indicator of improved health outcomes and health services. Accordingly, targets were not set for this measure for 2003/04.

Source: Medical and Pharmaceutical Services Division

Mental health services funding (including capital) per capita. (Goal 3: PM#3)

This indicator measures community mental health services funding relative to the adult population (over 19 years of age) in the province that rely on those services.

Results

2002/03 Target	2002/03 Actual	Status
4.2% increase Baseline: 2001/02	11.1% increase	Exceeded target

	2000/2001	2001/2002	2002/2003
Mental health services funding per capita	$106	$117	$130

Note: This rate is based on mental health community funding only with the addition of tertiary services (Riverview Hospital and Forensic services).

Source: Adult Mental Health Division, Ministry of Health Services

Goal 3: A Sustainable, Affordable Public Health System	
Objective 2: Reduce the burden of cost on the public system.	
Strategies:	
• Restructure user fees for selected non-*Canada Health Act* services to reflect ability-to-pay.	Completed
• Implement a framework for increased private sector involvement in capital financing, in the delivery of health services, and in the development and implementation of necessary information technology systems.	Underway

Achievements:

- Government announcement February 24, 2003 that a new Fair PharmaCare plan would come into effect on May 1, 2003. Fair PharmaCare provides financial assistance for eligible prescription drugs, based on families' ability to pay.
- In January 2003, government announced its intent to pursue a public private partnership (P3) to build a new hospital and cancer centre in Abbotsford. Clinical services continue to be provided by the publicly-funded health care system.
- The Patient Service Delivery Framework was developed to create policy for private sector partnerships for delivering clinical services under the *Canada Health Act*.

Goal 3: A Sustainable, Affordable Public Health System	
Objective 3: Appropriate organizational capacity to manage the health care system and efficiently deliver necessary services.	
Strategies:	
• Implement an information technology plan that incorporates shared, standardized business systems across regions.	Underway
• Restructure the regional health services delivery system.	Completed
• Reorganize the Ministry of Health Services to better support the health system.	Completed
• Implement a definitive accountability strategy that includes: — Clear expectations for performance, — Performance contracts for health authorities, — Routine reporting and monitoring, — Comprehensive assessment using agreed upon performance indicators, and — Opportunities for support and assistance for performance improvement.	Completed
• With the Ministry of Health Planning, develop and implement efficiency mechanisms for the Medical Services Plan, PharmaCare, laboratory services, ambulance and regional programs.	Underway
• Review the provision of ambulance services.	Underway
• Work with the health authorities and professional associations to implement strategies to support effective and appropriate use of the health care workforce.	Underway (Moved to the Ministry of Health Planning)
• Establish a Leadership Council of health authority CEOs and senior government officials, to provide overall guidance and leadership to the health system.	Completed
• Manage within the three-year funding target.	Underway

Achievements:

- Developed and published the following plans: Information for Health — A Strategic Plan for Health Information Management in British Columbia 2002/03 - 2006/07 (Dec. 2003) and Framework for an Electronic Health Record for British Columbians (Jan. 2003)
- HIV/AIDs service contracts were transferred to health authorities in April 2002. Administration and management for direct service contracts, including funding for the Aboriginal Health Initiatives Program, was transferred to health authorities in December 2002.
- Health system redesign planning and implementation are taking place in all health authorities. Performance agreements were introduced in 2002/03. A monitoring framework is being developed for each service, including acute care, mental health services, population and preventative health, and home and community care.

- Government announcement February 24, 2003 that a new Fair PharmaCare plan would come into effect on May 1, 2003. Fair PharmaCare provides financial assistance for eligible prescription drugs, based on families' ability to pay.
- Reviews of laboratory services and the ambulance service were conducted with recommendations expected in 2003.
- An Inter-professional Rural Placement Program (IRPP) is underway to provide team clinical education for medical, nursing and allied health students. The HSPnet development project, a Web-based system for clinical education matches, is complete. The province consulted with the six health authorities and conducted an environmental scan of health human resources to provide a solid basis for long-term health human resource planning.
- Regular meetings of the Leadership Council, comprised of health authorities, CEOs and senior ministry executive, has enhanced communication and collaboration between government and its system partners.

Performance Measures

Regional financial status (health authorities in a balanced budget position at year-end) (Goal 3: PM#2)

To ensure BC's health care system is sustainable, it is essential that expenditures on health care delivery by system partners remain within budget. This measure is intended to signal that each of the five geographic health authorities (HA's) and the Provincial Health Services Authority (PHSA) must ensure that their expenditures do not exceed their revenues over the three-year period of 2002/03 - 2004/05.

Results

2002/03 - 2003/04 Target	2002/03 Actual	Status
Expenditures will not exceed revenues	All health authorities are in a surplus position.	Met target

Source: Finance and Decision Support Division, Ministry of Health Services

Deregulation

2002/03 Target	2002/03 Actual	Status
4.5%	4.5%	Met target

The Ministry of Health Services achieved its deregulation target of 4.5 per cent in 2002/03. A major part of this reduction was the repeal of three obsolete or redundant regulations under the *Health Act*. The repealed regulations were the Frozen Food Locker Plant Regulation, the Sterilization of Rags Regulation and the Summer Camps Regulation.

Report On Resources

2002/03 Resource Summary by Core Business Area

	Estimated[2]	Other Authorizations[3]	Total	Actual	Variance
Operating Expenses ($000)					
PharmaCare	718,273	—	718,273	727,664	(9,391)
MSP	2,517,611	—	2,517,611	2,460,818	56,793
Emergency Health Services (Ambulance Services)	187,566	—	187,566	205,371	(17,805)
Regional Health Sector Funding	6,337,251	(1)	6,337,250	6,373,591	(36,341)
Capital Financing	305,900	—	305,900	275,443	30,457
Corporate Services and Program Management	138,799	(5,373)	133,426	130,718	2,708
Special Accounts (and SA Recoveries)	—	95	95	—	95
Total	**10,205,400**	**(5,279)**	**10,200,121**	**10,173,605**	**26,516**
Full-time Equivalents (FTEs)					
Total	**2,789.0**	**0.0**	**2,789.0**	**2,663.4**	**125.6**
Ministry Capital Expenditures (CRF) ($000)					
PharmaCare	—	—	—	—	—
MSP	—	—	—	—	—
Emergency Health Services (Ambulance Services)	10,155	—	10,155	9,124	1,031
Regional Health Sector Funding	—	—	—	—	—
Capital Financing	—	—	—	—	—
Corporate Services and Program Management	13,735	—	13,735	11,488	2,247
Total	**23,890**	**—**	**23,890**	**20,612**	**3,278**

Report On Resources

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Consolidated Capital Plan Expenditures (CCP) ($000)					
PharmaCare	—	—	—	—	—
MSP	—	—	—	—	—
Emergency Health Services (Ambulance Services)	—	—	—	—	—
Regional Health Sector Funding	—	—	—	—	—
Capital Financing*	272,900	—	272,900	116,721	156,179
Corporate Services and Program Management	—	—	—	—	—
Total	**272,900**	**—**	**272,900**	**116,721**	**156,179**
Other Financing Transactions ($000)					
Health Innovation Incentive Program (HIIP)	—	—	—	—	—
Receipts	1,362	—	1,362	1,125	237
Disbursements	—	—	—	—	—
Net Cash Source (Requirements)	1,362	—	1,362	1,125	237

* Excludes $55.2M Estimated and $31.5M Actual for the Regional Hospital Districts' share of capital financing.

Breakdown of Other Authorizations —

Statutory Appropriation — Special Account	16,238
Program Transfer, Order In Council 744	(5,373)
Program Transfer, Order In Council 935	(1)
Inter-account transfer	(16,143)
	(5,279)

2002/03 Resource Summary Mirroring the *Estimates* Vote Structure

	Estimated	Other Authorizations	Total	Actual	Variance
Operating Expenses ($000)					
Minister's Office	1,090	—	1,090	907	183
Program Management and Corporate Services	130,600	(5,373)	125,227	122,885	2,342
Emergency Health Services	187,566	—	187,566	205,371	(17,805)
Medical Services Plan	2,517,611	—	2,517,611	2,460,818	56,793
PharmaCare	718,273	—	718,273	727,664	(9,391)
Regional Health Sector Funding	6,337,251	(1)	6,337,250	6,373,591	(36,341)
Debt Service Costs	179,400	—	179,400	151,574	27,826
Amortization of Prepaid Capital Advances	126,500	—	126,500	123,869	2,631
Recoveries from Health Special Account	(144,500)	—	(144,500)	(144,595)	95
Vital Statistics	7,109	—	7,109	6,926	183
Health Special Account	144,500	95	144,595	144,595	—
Medical and Health Care Services Special Account	15,000	16,143	31,143	16,143	15,000
Transfer from Ministry Operations Vote to the Medical and Health Care Services Special Account	(15,000)	—	(15,000)	—	(15,000)
Transfer from the Medical and Health Care Services Special Account to the General Account	—	(16,143)	(16,143)	(16,143)	—
Total	**10,205,400**	**(5,279)**	**10,200,121**	**10,173,605**	**26,516**
Full-time Equivalents (FTEs)					
Total	**2,789.0**	**0.0**	**2,789.0**	**2,663.4**	**125.6**

	Estimated	Other Authorizations	Total	Actual	Variance
Ministry Capital Expenditures (CRF) ($000)					
Minister's Office	—	—	—	—	—
Program Management and Corporate Services	12,135	—	12,135	10,673	1,462
Emergency Health Services	10,155	—	10,155	9,124	1,031
Medical Services Plan	—	—	—	—	—
PharmaCare	—	—	—	—	—
Regional Health Sector Funding	—	—	—	—	—
Debt Service Costs	—	—	—	—	—
Amortization of Prepaid Capital Advances	—	—	—	—	—
Recoveries from Health Special Account	—	—	—	—	—
Vital Statistics	1,600	—	1,600	815	785
Total	**23,890**	**—**	**23,890**	**20,612**	**3,278**
Consolidated Capital Plan Expenditures (CCP) ($000)					
Prepaid Capital Advances*	272,900	—	272,900	116,721	156,179
Other Financing Transactions ($000)					
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	(5,279)

2002/03 Resource Summary — Explanation of Significant Variances

Core Business	Surplus / (Deficit)	Explanation of Variance
Emergency Health Services	(17,805)	This deficit is the result of increased call volumes and enhanced training for paramedics.
Medical Services Plan	56,793	This surplus is the result of: implementation delays in Primary Health Care projects; underspending physician services; and reduced utilization of Supplementary Benefits services.
PharmaCare	(9,391)	This deficit is due to the delayed implementation of Fair PharmaCare.
Regional Health Sector Funding	(36,341)	This deficit results from two issues: (1) one-time Home and Community Care transition funding to health authorities, and (2) transfer of the Home Oxygen Program from PharmaCare (the budget is reflected in PharmaCare).
Debt Service Costs	27,826	This surplus is due to reduced debt servicing charges from the Ministry of Finance.

Major Capital Projects

Commitments or anticipated commitments for 2003/04 have been made to the following major capital projects:

- Vancouver General Hospital Redevelopment, $156 million
- Prince George Hospital Redevelopment, $50 million
- P3 Projects
  - — Abbotsford Hospital and Cancer Centre (P3 solicitation process underway)
  - — Academic Ambulatory Care Centre (P3 solicitation process underway)

The objective of these projects is to provide high quality public health care services that meet patients' needs. The risks associated with these projects include: project delays; changes in market conditions; scope, design and technology changes; building code changes; and cost-sharing agreements with other jurisdictions.

The ministry's three-year capital spending plan for 2002/03 included:

- $100 million for converting existing facilities to more appropriate uses consistent with the new regional priorities. At March 31, 2003, $25.47 million has been approved from this allocation.
- $138 million to implement the Mental Health Plan (e.g. Tertiary Mental Health Facilities in Kamloops). At March 31, 2003, $21.13 million has been approved from this allocation.

Capital Asset Management Plans

In May 2002, government established a new capital asset management framework, which articulates the Province's minimum standards for capital asset management. The framework encourages agencies to prepare capital asset management plans and to review all options for addressing infrastructure needs. The Ministry of Health Services is working with health authorities to implement the new framework. In this respect, an implementation plan has recently been completed which includes the prioritization of key elements for which ministry policy and/or tools to support best practices in capital asset management are required.

To support the health authorities and the ministry in preparing capital asset management plans, a Residential Care Facility assessment project was completed in 2002/03 and an Acute Care Facility inventory and assessment project started in 2002/03.

Consolidated Capital Plan Expenditures (CCP) ($000)			
02/03	Estimate	Actual	Variances
Prepaid Capital Advance (Ministry Share)	272.9	116.7	156.2
Regional Hospital District Share (for cost shared projects)	55.2	31.5	23.7
Total	**328.1**	**148.2**	**179.9**

The variance is primarily due to under spending on health authority restructuring capital projects.

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Summary of Other Planning Processes

Information Resources Management Plan (IRMP)

The implementation of government's Common IT Services Organizations (CITS) changed the role of the ministries' Information Management Group (IMG). This group has undergone a strategic shift to focus on IM/IT planning, partnership building, standards setting, business consulting, project management, information services, and e-health for the province. IMG continues to provide support for both the Ministry of Health Services and the Ministry of Health Planning.

Information technology is a tool to enhance patient care by allowing family physicians to collaborate with specialists, nurses and other health professionals. A number of strategies and projects were launched in 2002/03 to develop a foundation for an integrated network of care.

The Health Chief Information Officers Council (CIO Council) was established to develop a strategic plan for information management and ongoing collaboration. The council developed these documents:

- Information for Health — A Strategic Plan for Health Information Management in British Columbia 2002/03 - 2006/07; and,
- Framework for an Electronic Health Record for British Columbia.

A number of key projects are underway to support establishing an Electronic Health Record (EHR) that improves patient care and clinical decision-making with due attention to security and privacy protection. These include:

- A Physician IM/IT Strategy to develop a common approach for electronic access to clinical information.
- An Electronic Medical Summary to provide key patient information.
- New infrastructure to address access and network issues.
- BC Healthcare Client Identity Management Strategy to provide accurate, consistent, and unique identification of clients.
- Provider Registry Uptake supports the use of this registry, a standards-based repository of core data on health care providers.
- Electronic Health Record (EHR) Architecture to ensure a common framework for related projects.
- Diagnostic imaging services and infrastructure to make the results of diagnostic services, such as X-rays, MRIs and CT scans, available online securely.
- Clinical Broker Strategy facilitates the exchange of clinical information among organizations.
- PharmaNet Uptake to enable the use of PharmaNet drug history data to aid in clinical decision making.

Another goal is to make health information and services available electronically to the public to help them prevent illness, learn about treatment options, enhance wellness and access services online. The following IT projects are underway:

- Fair PharmaCare online registration;
- BC HealthGuide Program consisting of the BC HealthGuide Handbook, companion First Nations Health Handbook, BC HealthFiles, BC NurseLine and BC OnLine;
- Web-based public consultation for the *Community Care Facility Act* (Bill 16);
- Surgical Wait List Registry;
- Public Web sites such as BC Health Care, Your Health, BC Online and Chronic Disease Management; and
- An inter-ministerial Library Web site that provides access to an online catalogue and evidence-based research links.

Human Resource Management Plan (HRMP)

The Ministry of Health Services provides support services for human resource planning for both the Ministry of Health Services and the Ministry of Health Planning. Both ministries are involved in organizational planning and workforce adjustment to build capacity and meet operational requirements resulting from the Core Review, budget reductions and other government initiatives. The 2002/03 Human Resources Management Plan supports the following key goals:

Organization Planning — A skilled and competent workforce capable of delivering on new ministry goals

- 2003/04 Human Resources Management Plan refocused and revised

Workforce Adjustment — Redundant positions and surplus employees identified and people affected are treated with fairness, consideration and subject to due process.

Since the inception of the three-year workforce adjustment in 2001, the following has been completed:

- 453 encumbered and 200 vacant positions have been eliminated;
- Over 100 auxiliary employees were laid off; and
- Approximately 300 employees finished employment under the voluntary departure program.

In 2002/03, the following human resources strategies were implemented:

- Retirement projections were provided to senior managers.
- A Transition Resource Center was established to provide support to managers and employees. Services were offered to 1,051 workshop participants, including 1,027 individual coaching/counseling sessions.
- Approximately 300 employees finished employment under the voluntary departure program.

Employee Learning — Skilled, capable learning employees that support achievement of ministry goals

- 840 participants received a variety of formal training

Appendix 1: Acts under the Administration of the Minister of Health Services

Access to Abortion Services Act
Anatomy Act
BC Benefits (Income Assistance) Act, insofar as it authorizes the Healthy Kids Orthodontia Program
Community Care and Assisted Living Act
Community Care Facility Act
Continuing Care Act
Drinking Water Protection Act
Food Safety Act
Forensic Psychiatry Act
Health Act, except ss. 2 to 7
Health and Social Services Delivery Improvement Act, except Part 3
Health Authorities Act
Health Care (Consent) and Care Facility (Admission) Act
Health Emergency Act, except ss. 6-9, 14 (2)(a) and (b)
Health Special Account Act
Hospital Act
Hospital District Act
Hospital Insurance Act
Human Tissue Gift Act
Meat Inspection Act
Medicare Protection Act, except ss. 3 – 6
Mental Health Act
Milk Industry Act, s. 12, except in respect of tank milk receiver licences
Ministry of Health Act
Pharmacists, Pharmacy Operations and Drug Scheduling Act, ss. 37 – 39
Public Toilet Act
Venereal Disease Act

Appendix 2: 2002/03 Legislative Changes

Ministry of Health Services

Community Care and Assisted Living Act (Bill 73)

This Bill created a new regulatory framework for:

community care facilities and

assisted living residences.

The new legislation streamlined processes, supported an outcome-based regulatory model, and modernized the former *Community Care Facility Act*. It also added a new section to protect the health and safety of residents of assisted living residences.

Drinking Water Protection Amendment Act, 2002 (Bill 61)

This Bill amended the *Drinking Water Protection Act* to ensure that better planning and greater accountability are in place for high-quality drinking water throughout the Province. It established:

- the protection of public health as a guiding principle;
- clear lines of responsibility within government;
- the role of the Provincial Health Officer in monitoring; and
- new drinking water officers across the Province.

Food Safety Act (Bill 37)

This Bill combined and streamlined various existing requirements for licensing and inspection. It sets standards in relation to milk, meat and fish products, as well as food premises. It repeals the *Meat Inspection Act* and the food safety aspects of the *Milk Industry Act* and *Fish Inspection Act*. It permitted harmonization of standards and processes with other jurisdictions.

Health Authorities Amendment Act, 2002 (Bill 60)

The Bill made minor amendments to the *Health Authorities Act* to reflect the December 2001 amalgamation of 52 health authorities into 5 regional health authorities and one provincial health services authority. It removed obsolete references and made other minor housekeeping changes.

Health Care (Consent) and Care Facility (Admission) Amendment Act, 2002 (Bill 44)

This Bill introduced new provisions that prevent health care providers from acting in an emergency situation if it would be contrary to previously expressed wishes of the patient. Health care providers are authorized to treat despite a refusal of treatment by a substitute decision-maker iff the substitute decision-maker has not complied with the legislation and treatment is necessary to preserve life, prevent serious harm, or alleviate severe pain. Other amendments improved the efficient operation of consent legislation.

Health Services Statutes Amendment Act, 2002 (Bill 18)

This Bill amended the *Hospital Insurance Act* to harmonize the eligibility requirements for hospital services with medical services. Miscellaneous amendments to the *Medicare Protection Act* did the following:

- Eliminated the power of the Medical Services Commission to de-enroll physicians from MSP at the age of 75;
- Improved the audit process to include the collection of interest on monies owing from inappropriate or fraudulent billings;
- Increased the efficiency of the Medical and Health Care Services Appeal Board; and
- Allowed private insurers to provide some coverage for people on premium assistance for supplementary services.

Deregulation/Miscellaneous Amendments

Deregulation Statutes Amendment Act, 2002 (Bill 8)

Deregulation Statutes Amendment Act (No. 2), 2002 (Bill 35)

As part of Government's deregulation initiative, portions of these Bills repealed the *Supplement to the Health Act*, the *Health Research Foundation Act*, and Part 3 of the *Hospital Act*. Minor amendments were also made to the *Name Act*, *Wills Act*, and the *Vital Statistics Act*.

Miscellaneous Statutes Amendment Act (No. 2), 2002 (Bill 54)

This Bill amended the *Mental Health Act* by amending the composition of review panels. The Minister of Health Services appoints all review panel participants to a board whose chair will then select the three persons for each review panel, including a designated patient representative.

Appendix 3: Update on *New Era* Commitments

New Era Commitment	Status	Action
Maintain this year's overall $9.3 billion budget for health.	Done	Health budget was increased in 2002/03.
Provide health regions and hospitals with 3-year rolling funding commitments (updated annually), to enable them to plan and act with certainty.	Done	3-year rolling funding commitments were provided to health authorities with the 2002/03 budget.
Fund health regions at a level necessary to meet the needs of the people who live there, regardless of where a service is provided.	Done	Overall funding for health authorities increased by 7.8% in the 2002/03 budget. Also, population needs-based funding was implemented for the 2002/03 health authority funding allocations.
Fulfill BC's obligations under the Canada Health Act to properly fund and provide access to all medically necessary services.	Ongoing	Health funding was increased in the 2002/03 budget and health authorities have been provided three-year funding commitments.
Focus funding on patient care, by reducing waste in the system and eliminating administrative duplication and costs from provincial government mismanagement.	Done	The number of health authorities has been reduced from 52 to 6 to achieve greater efficiency; and the health ministries' administration budget is being reduced by more than 40 per cent so those resources can be redirected to patients.
Work to minimize inter-jurisdictional overlaps that are adding confusion and costs to health care delivery.	Done	The number of health authorities has been reduced from 52 to 6, to provide greater efficiency and coordination within regions.
With IGR and Finance, negotiate with the federal government to restore all of the health care funding withdrawn through budget cuts.	Ongoing	The First Ministers Accord on Health was completed in February 2003. The Accord will result in an increase in federal funding for health services.
Protect existing levels of access to abortion services throughout the province.	Done	Funding and access to abortion has been maintained.
Support community services volunteers and repeal legislation that allowed government to expropriate community health facilities without compensation.	Done	The section of the Health Authorities Act allowing assets to be seized without compensation was repealed in August 2001.
Fully fund and implement the $125 million mental health initiative.	Done	Government is implementing a $263 million mental health commitment, including the $125 million mental health plan and $138 million for capital and facilities.

New Era Commitment	Status	Action
Provide expanded home care and palliative care services to assist chronically and terminally ill patients with supportive home environments as an option to institutional care.	Ongoing	Health authorities have implemented housing options such as assisted living residences and supportive housing units. They are also increasing the number of hours provided to high care needs clients receiving care at home. Palliative care services are being provided at home, including medications and supplies thus decreasing the need for facility admissions. These initiatives are allowing clients to remain as independent as possible in their own homes.
Ensure that patients living at home in palliative or long term care are entitled to the same pharmaceutical benefits as they would have if they were in a hospital.	Underway	The government has introduced a new Palliative Care Benefits program to support seniors and other individuals who are terminally ill by providing medication, medical supplies and equipment at no charge to clients in their homes.
Provide better home support and home care services.	Ongoing	New provincial standardized assessment tools for home care and residential care have been successfully tested and validated. The ministry has mandated the use of the assessment tools as part of health authority performance expectations. These new tools provide a comprehensive assessment of client needs and will result in the right care being provided to the right client at the right time. The tools are a critical component of effective case management, planning, resource allocation and outcome measures.
Work with non-profit societies to build and operate an additional 5,000 new intermediate and long term care beds by 2006.	Underway	As a first step, Independent Living BC was established in April 2002 to develop 3,500 supportive living units.

New Era Commitment	Status	Action
Intensify efforts to promote wellness and preventative care through better education, dietary habits and physical activity.	Ongoing	Government funding for physical fitness and amateur sports has been increased and total funding will double over 4 years, and ministry activities have intensified to address physical activity, healthy eating, obesity and injuries. MOHP has initiated Action Schools! BC, a best practices physical activity model designed to assist elementary schools in creating school action plans to address physical activity and healthy living. MOHP has also facilitated the formation of the Provincial Chronic Disease Prevention Alliance with non-governmental stakeholders to address the risk factors of physical inactivity, unhealthy eating, obesity and tobacco. MOHP continues to work with health authorities in the development of a directional policy document, which addresses physical activity and healthy eating. The Provincial Health Officer will release a special report on prevention of falls in the elderly this summer.
Increase emphasis on early childhood intervention programs for families with special needs children.	Done	With MCFD, the ministry improved access to assessment and diagnostic services for children with autism. Funding for early childhood and family development increased by $20 million (MCFD).
Enhance preventative drug and alcohol efforts, such as addiction counseling for new mothers and the reduction of fetal alcohol syndrome.	Ongoing	Government has joined the Prairie Northern Pacific Fetal Alcohol Syndrome Partnership. In addition, an addictions framework is being developed that includes alcohol, drug and FAS prevention.
Increase locum support to relieve pressure and reduce workloads to enhance health care professionals' quality of life.	Done	Utilization and funding of the Northern and Rural Locum Program has increased. In addition, in March 2003 government implemented an interim Rural Specialist Locum Program ($1 million) to help specialists secure subsidized periods of leave from their practices to undertake continuing education or vacation.

New Era Commitment	Status	Action
Replace obsolete hospital and ambulance equipment and ensure all equipment is fully utilized and properly maintained.	Ongoing	Ambulances have had new cardiac defibrillation equipment installed (all 454 ambulances now have defibrillators). Health authorities receive $115 million annually for capital improvement projects and equipment
Give ambulance attendants better access to training.	Done	The government funded communication upgrades and training for 1,500 new recruits and part-time personnel for Paramedic Level 1, ensuring more timely and effective emergency care, particularly in rural and remote communities.
Increase technology funding and digital infrastructure support to facilitate telehealth options that will expedite and improve treatments and reduce travel requirements for Northern and rural residents.	Underway	Government is funding $15 million in telehealth programs across BC, with federal and local partners, including the new BC Telehealth Project launched in February 2002. The programs provide emergency and trauma, pediatric, maternity and mental health services for 30 communities.
Build a unified, universal and cost-effective health services information network that will improve care and reduce costs.	Underway	The Health Chief Information Officers Council was formed in April 2002 and has produced a five-year Strategic Plan for Health Information Management in BC and a Framework for an Electronic Health Record for BC. The CIO Council is chaired by the CIO of the health ministries and consists of the CIO's from each of the six health authorities.
Give all citizens better access to their medical records and treatment histories, and enhanced information privacy rights.	Underway	The Health Chief Information Officers Council has published a Framework for an Electronic Health Record for British Columbians (January 2003).